PREMIER
PHYSICAL • THERAPY

NPP 2023

Name _____

Phone _____ Date of Birth _____

Address _____ SSN #_____

Email _____

Employer _____ Work Ph# _____

Occupation _____

Emergency Contact

Name_____ Phone# _____

Relationship to Patient_____

Is this for an automobile accident? Yes No N/A
If so, in what state did the accident occur? _____
What is your adjuster/case manager's name: _____
Adjuster/case manager's Ph# _____
Translator's name/ph#(if applicable) _____

How did you hear about our clinic? _____
I allow Premier to use my image and feedback on the Facebook page and website.
(select one) Yes No

Appointment Reminder Consent

I would prefer to receive (select one): _____ Text _____ Voicemail

Insurance & Financial Responsibility

We contact your provider to identify your benefits as a courtesy to you, our patient and is NOT a guarantee of payment. **It is the individual policyholder's responsibility to know what is covered and not covered, to know your co-pay and/or your deductible balance.** Benefits are subject to change; secondary forms of insurance are not guaranteed to pay the remainder from primary. Know that if your insurance does not pay the entire balance, then the **total balance owed will be considered due and payable**. If your insurance company rejects your claim, or if they pay less than the total bill, **you are responsible for paying the balance in full.** Any durable medical equipment required will be self-pay.

I understand my financial responsibilities (please initial) _____

By signing I verify that the above information is correct to the best of my knowledge.
Signature: _____ Date: _____