

# Buffalo Physical Therapy



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Physical Therapist

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Physical Therapist

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82801

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OTR/L  
Occupational Therapist

P: 307-684-8623  
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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Appointment contact preference if other than phone:

Email: \_\_\_\_\_ Text Provider: AT&T Verizon Other: \_\_\_\_\_

Sex: M F Referring Physician: \_\_\_\_\_

Injured Area: \_\_\_\_\_ Date of Surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_

Work Related: NO YES – See Work Comp Info below Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

How did you hear about us? Web Radio Brochure MD Friend Other: \_\_\_\_\_

## Insurance – Please present card/info to receptionist

If Primary cardholder is not patient please complete the following: Primary Secondary

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Relationship to policy holder: \_\_\_\_\_

## Workman's Compensation

Claim Number: \_\_\_\_\_ SSN: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ State of Injury Claim: WY Other: \_\_\_\_\_

## Auto Insurance – For Auto Accidents Only

Claim Number: \_\_\_\_\_ Insurance: \_\_\_\_\_

Ins. Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

## Our Policies

### Appointment Policies:

The primary reason for appointments is to make efficient use of your time and our time. We make every attempt to provide your treatment on your scheduled time. If you need to cancel an appointment we do ask that you give us as much advance notice as possible. Three (3) or more missed appointments may result in discontinuation of future treatments.

### Payment Policies:

By accepting treatment services provided by Sheridan Physical Therapy you are accepting final financial responsibility. We are happy to submit all service charges to the insurance you have provided to us. Any co-payment and/or deductible will remain your responsibility. You are responsible for contacting your insurance company to determine how they handle physical therapy, occupational therapy and/or speech therapy charges. **We will not bill insurance for any visits paid by cash discount.**

### Workman's Compensation Policies:

We are happy to bill Workman's Comp for related injuries. We do require that you provide claim number, date of injury, and billing address. We are required to notify your physician, employer, and claims adjuster regarding any missed appointments. Three (3) missed appointments may result in discontinuation of further treatments.

### Medicaid Policy:

All Medicaid patients are required to pay \$2.00 per visit co-pay at time of visit

### Bracing/Materials/Supplies Policy:

We **DO NOT** bill insurance for any items that are purchased from this facility. Payment is expected at time of purchase.

### HIPPA:

I authorize release of my medical records to my referring physician. I understand that I am financially responsible for all charges whether or not they are paid by stated insurance. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment be authorized and benefits be made on my behalf and payable to the appropriate provider. I authorize my signature as the insured or as legal on behalf of the insured. This assignment will remain in effect until revoked by me in writing. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. 1.5% interest (18% per annum) will begin to accrue thirty (30) days after first statement has been sent to patient. I will also be charged a \$2.00 rebilling fee for each statement sent. Should I have questions about HIPPA or my rights for privacy and portability of medical records I am aware that I should contact Sheridan Physical Therapy's HIPPA complaint officer.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_