Welcome To WCPT, LLC

Thank you for choosing Whatcom Community Physical Therapy, LLC.
We look forward to helping you meet your rehabilitation needs.
To help us serve you more efficiently, please fill-out, read, sign, and date in the designated areas.

Patient's First Visit Date	Physical Therapist's Name	Patient's New Account Number

Patient Information

Patient Name *(Last, First Middle Initial)*	SSN *(Social Security Number)*	DOB *(Date Of Birth)*

Sex ☐M*(Male)* ☐F*(Female)*	Marital Status ☐Married ☐Single ☐Divorced ☐Widow	Email	Home or Cell Phone

Street Address *(Mailing Address)*	City, State, Zip

When was your last physician visit? *(Date/Dates)*	Referring Physician's Name	Was this an auto accident? ☐Yes ☐No	Work related accident? ☐Yes ☐No	Date of the accident?

Tell Us About Your Injury	Attorney's Name

Whom may we call in case of emergency?	Relation to you?	Phone

Whom may we thank for referring you to our clinic?

☐ Attorney ☐ Billboard/Sign/Location ☐ Doctor ☐ Insurance Provider ☐ Newspaper ☐ Phone Book ☐ Radio
☐ Return Patient ☐ Television ☐ Website ☐ Family Or Friend ☐ Other: ____________________________

Responsible Party

Responsible Party Name or Business Name	Relationship to Patient	Phone

Street Address *(Mailing Address)*	City, State, Zip

Insured Party's SSN *(Social Security Number)*	Insured Party's DOB *(Date Of Birth)*	Other Information

Responsible Party Employer

Employer's Name	Employer's Phone

Employer's Address	City, State, Zip

Patient Or Spouse Employer

Employer's Name	Employer's Phone

Employer's Address	City, State, Zip

Consent For Care And Treatment

I, the undersigned, do hereby agree and give my consent for WCPT, LLC PT to furnish medical care and treatment to ____________________________ *(Patient's Name)*
as considered necessary and proper in diagnosing or treating his/her physical and condition.

______________________________ ______________________________ ____________

Patient and/or Guardian Signature Patient and/or Guardian Print Name Today's Date

Benefit Assignment/Release Of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to WCPT, LLC. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment or to communicate with other healthcare providers.

Patient and/or Guardian Signature	Patient and/or Guardian Print Name	Today's Date

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full, from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to Whatcom Physical Therapy, LLC.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Insurance Information

Primary Insurance		Mailing Address *(City, State, Zip)*			Phone
Group and/or Claim #		Member Id #		Adjuster/Case Manager	
Co-Pay or %	Deductible	Amount Met	Max Pt. $ /Visits	$/Visits Used	Effective Date
Secondary Insurance		Mailing Address *(City, State, Zip)*			Phone
Group and/or Claim #		Member Id #		Adjuster/Case Manager	
Co-Pay or %	Deductible	Amount Met	Max Pt. $ /Visits	$/Visits Used	Effective Date

Patient's Responsibility

Ded To Meet	Co-Pay/Coins	Arrangement

NOTE: Estimated coverage information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me.
I understand my full responsibility for the payment of my account.

Patient and/or Guardian Signature	Patient and/or Guardian Print Name	Today's Date

Authorized WCPT Representative's Signature	Authorized WCPT Representative's Print Name	Today's Date