

Barker Physical Therapy Clinic

Name:	DOB:
Address:	Cellphone:
City, State, Zip:	Home Phone:
Email Address:	

Insurance Information (Required). Please provide your insurance card or complete this section in full.

Insurance Company:
Member ID:
Group Number:
Policy Holder Name:

Third Party/Claim Information (circle Y or N)

Workers Comp Y or N

Auto Insurance Y or N

Litigation Y or N

If YES to any of the above, additional documentation must be provided prior to or at the time of your visit.

Cancellation / Rescheduling Policy (Initial after reading)

_____ Barker Physical Therapy Clinic has a 12 hour cancellation/rescheduling policy. If you cancel or change your appointment with less than 12 hour notice, you will be charged \$30.00 for the first two occurrences and \$50.00 for a third or more occurrences. No show fee is \$50.00.

Patient Financial Policy (Initial after reading)

_____ •All copays, cash services, dry needling, and supplies not covered by insurance are due at the time of service.

- Balances over \$250 or from previous years must be paid before scheduling additional visits.
- Patients are responsible for third-party claims and denied insurance balances
- A 3% surcharge applies to credit card transactions.
- Cash pay options/packages are available upon request.

HIPAA Privacy Notice

HIPAA protects individual health information while allowing necessary access for treatment, payment, and healthcare operations. Full HIPAA privacy documentation is available upon request.

Signature: _____ **Date:** _____