Idaho State University

ISU Physical & Occupational Therapy Associates
1400 Terry Dr., Bldg. 63, Pocatello, ID 83209
Phone: 208.282.2590 / Fax: 208.282.4962

Patient Demographics

Patient Name: _____ **DOB:** _____

Address: _____ **Sex:** ☐ Male ☐ Female

_____ **SS No:** _____

Home/Cell Phone: _____ **Work Phone:** _____

It is ok for us to leave a message regarding your treatment at the following phone numbers? ☐ Home ☐ Cell ☐ Work

Primary Language: _____

Primary Physician: _____ **Office Phone:** _____

Referred By: _____ **Office Phone:** _____

Insurance Information

Insurance Provider(s): (Please check all that apply)

☐ Blue Cross ☐ Regence BS ☐ Medicare ☐ Medicaid ☐ Pacific Source

☐ Select Health ☐ VA ☐ Ameriben ☐ UHC ☐ Tricare

☐ Private Pay ☐ Student Health ☐ Other: _____

Primary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Secondary Subscriber ID: _____ **Group No.:** _____

Subscriber Name: _____ **DOB:** _____

Address: (if different from above) _____

Employer: _____ **Student Status:** ☐ FT ☐ PT

Billing Policy

We bill all major insurance companies. We recommend a physician's referral or prescription for services. **Medicare and Medicaid patients are required to have a physician's referral**. All co-pays and estimated co-insurance will be collected at the time of service. If you do not have insurance and have limited financial resources, you may be able to qualify for a discount. If you qualify for a fee reduction, a partial payment may be due at the time of service. At a minimum, payments must be made monthly. Accounts past due more than 90 days will be sent to collections and any cash discounts applied will be removed and you will be responsible for regular therapy pricing.

Consent

I authorize Idaho State University to release information necessary to process insurance claims on my behalf. I understand that I am responsible for all co-pays, co-insurance, deductibles and non-covered charges and understand the billing policy as stated above. I also understand that supervised graduate students may participate in the evaluation and treatment of the patient as part of their educational program, and hold ISU harmless for any incident related to this treatment.

Signed By: _____ **Date:** _____

Parent/Guardian or Responsible Party