

PATIENT REGISTRATION FORM

Patient Name _____

ID # _____

Patient Address _____

Today's Date _____

City, State, Zip _____

Referring MD _____

Home Phone () _____

Was this an auto accident? _____

Work Phone () _____

Date of injury _____

Cell Phone () _____

E-mail _____

SS# or DL# _____

Birthdate ___/___/___ Age ___

Employer Name _____

Gender: M F Student: Y N

Employment Status: Full Part-Time N/A

Marital Status: M S D W

Have you received Home Health Care within the last 3 months? Yes No

Have you received Physical Therapy or Speech Therapy at ANY other facility THIS calendar year? Yes No

Please fill out if you are not the insurance cardholder:

Subscriber's Name: _____ DOB: ___/___/___

Relationship to Patient: _____ Place of employment _____

If there is someone whom you would like us to release your information to other than your physician, please fill in their name:

Name Relationship

A copy of the Notice of Privacy Practices was offered to this patient:

Accepted Declined

Consent for Treatment

I hereby agree to have a licensed Physical Therapist perform an evaluation and render appropriate treatment ordered by my physician. I also authorize the release of any information pertinent regarding my case to any insurance company, adjuster, or attorney involved in the case. I direct the insurer to directly pay, without equivocation, Physical Therapy One all benefits due them and guarantee payment for services.

Courtesy Claim Filing

It is the patient's responsibility to guarantee payment for physical therapy services at Physical Therapy One. As a courtesy, Physical Therapy One will file with your primary and/or secondary health insurance ONE TIME ONLY per visit. You will be responsible for any charges that have been denied by your insurance company. We will provide any necessary information to assist in this filing process.

Cancellation Policy

Physical Therapy One requires 24-hour notice for any cancellation. A \$25.00 fee will be charged to your account for non-compliance including not showing for your appointment. More than 3 (three) cancellations/no-shows will result in an automatic discharge.

SIGN HERE _____ DATE _____

Medical History Information Sheet

Name: _____ Date: _____

1. Medications (Please list **or provide list for the receptionist to copy**):

2. Allergies to medications or latex (Please list):

3. Surgical History (Please list **any** surgeries & year they occurred):

4. Fractures (Please list any previous or current fractures & year they occurred):

5. Do you have a pacemaker? Yes No

6. Medical History

a. Please check if you have ever had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes/High Sugar | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Low Blood Sugar/hypoglycemia | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Blood clots/DVT | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures/epilepsy | <input type="checkbox"/> Infectious Disease (TB, HIV, hepatitis) |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Developmental or growth problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Other: _____ |

b. Please check if you have had in the past year:

- | | | |
|---|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Weakness in legs or arms | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Other: _____ |

Patient/Guardian Signature: _____

FINANCIAL AND BILLING POLICY

We will bill your insurance for you, but you should be aware of the following information:

BILLING YOUR INSURANCE: As a service to our patients, our office will bill your insurance carrier. The final responsibility for the entire balance belongs with you, the patient. You will be expected to pay for any charges that are not covered by your insurance, such as supplies, office visits, copays, deductibles or balances left from an insurance payment. Payment will be expected from you after 30 days from the date of billing. It is up to you to contact your insurance carrier regarding any problems or delays you might be experiencing with your claims, although we would be happy to address any questions that you have. We accept MASTER CARD AND VISA PAYMENTS, CASH OR CHECKS. We can also set up payment arrangements.

COURTESY CLAIM FILING

It is the patient's responsibility to guarantee payment for physical therapy services at PHYSICAL THERAPY ONE. As a courtesy, PHYSICAL THERAPY ONE will file with your primary, and or, secondary health insurance ONE TIME ONLY per visit. You will be responsible for any charges that have been denied by your insurance company. We will provide any necessary information to assist in this filing process.

What does "PARTICIPATE WITH INSURANCE" mean?

WE PARTICIPATE WITH select insurance companies. In most cases this means that we accept the amount that the insurance carrier pays as full payment for our services. You remain responsible for copays or deductibles even if we participate with your insurance carrier. We encourage you to contact your insurance carrier to verify your *physical therapy benefits*.

IF WE DO NOT PARTICIPATE WITH your insurance, we will still bill your carrier for you. However you are responsible for the amount not covered by your insurance carrier.

REFERRALS OR AUTHORIZATIONS If your insurance carrier requires a referral or authorization, these usually come from your primary care physician. Please make sure that this is in place BEFORE services are provided. If proper authorization is not obtained, you may be responsible for your entire balance.

LEGAL ACTIONS FOR PERSONAL INJURY if you are involved with legal action for personal injury, we do not accept this as a reason to delay payment for our services. Responsibilities of payment belong to the patient. We are happy to provide your attorney any information they request with a signed release from you and at a fee they will be required to pay for such records.

Please sign and date below that you accept and understand our financial and billing policy:

Patient

Responsible Party if different than patient Date