PHYS MED

Physical Therapy Clinics

PATIENT REGISTRATION (Please Print)

Patient Name: _____ SSN: _____ Sex: _____ Birthdate: _____

Mailing Address: _____ City: _____ Zip: _____ Home Phone: _____

Current Employer: _____ Work Phone: _____ Cell Phone: _____

Work Address: _____ City: _____ Zip: _____ Email- optional: _____

RESPONSIBLE PARTY (If patient is a minor)

Name: _____ SSN: _____ Sex: _____ Birthdate: _____

Mailing Address: _____ City: _____ Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Work Address: _____ City: _____ Zip: _____ Relationship to patient: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____ Cell Phone: _____ Home #: _____

INSURANCE INFORMATION (Check one) Personal Injury___ Auto Accident___ Slip & Fall___ Work Related___ Date of Injury_____

Primary Insurance: _____ Subscriber: _____ Subscriber's DOB: _____

ID#--Claim#: _____ Employer: _____ Relationship to patient: _____

Secondary Insurance: _____ Subscriber: _____ Subscriber's DOB: _____

ID#: _____ Employer: _____ Relationship to patient: _____

ATTORNEY INFORMATION

Attorney Name: _____ Phone: _____

Lien or auto accident related: Bill AUTO Insurance: YES NO Bill HEALTH Insurance: YES NO

PRIVATE HEALTH, LIEN, AUTO and MEDICARE AUTHORIZATION OF TREATMENT: I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are otherwise agreed upon. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the condition thereof. I authorize the release of the information required.

AGREEMENT: This information is for the purpose of obtaining credit and is warranted to be true.

WORKERS COMPENSATION AUTHORIZATION OF TREATMENT: Phys Med is hereby authorized to treat the above-named patient. The patient hereby represents that they are here to receive treatment for an injury or disease that has arisen out of their employment. In reliance on this representation, Phys Med will seek reimbursement directly from the patient's employer or it's insurer. The undersigned hereby assigns all proceeds of insurance for this treatment to Phys Med. If it is later determined that the injury did not arise out of the patient's employment, the patient agrees to assume liability for unpaid charges.

_____ _____

Signature of Patient (or guarantor if patient is a minor) Date

PHYS MED PHYSICAL THERAPY

FINANCIAL AGREEMENT

As a courtesy to our patients, we will contact your insurance provider before your first appointment to verify eligibility and your physical therapy benefit coverage. The information that is provided to us by your insurance company may not be accurate and is not a guarantee of payment. It is the patients responsibility to know their plan benefits and limitations prior to their first appointment and to also provide the most current insurance card to insure we have accurate information.
Please notify us immediately of any insurance plan changes that may occur during your course of physical therapy.

BILLING

It is our policy to bill your insurance carrier as a courtesy to you, although, you are entirely responsible for services rendered.
Phys Med Physical Therapy is bound contractually to accept negotiated rates with contracted insurance carriers. Your plan may include out of pocket expense such as co-pay, co-portion and/or deductible. **All CO-PAYS ARE DUE AT THE TIME OF SERVICE.** Phys Med will bill the patient or guarantor for any charges that are the patients responsibility, ie. co-portion/deductible, once the insurance company's explanation of benefits (EOB) is received. The EOB reflects the break-down of the patient responsibility. Your insurance may request additional information to process your claim. It is important that you respond to them within 15 days to avoid being billed for the charges.

WORKERS COMPENSATION INSUREDS – The above statement does not apply to patients receiving physical therapy services for a work related injury. However, the referral/PT must be authorized through your primary/WC physician. Please be aware that if the WC insurance carrier has released, cancelled or your claim has been denied, the patient will be financially responsible for all charges incurred.

MEDI-CAL RECIPIENTS – Phys Med will bill for your services. However, if at any time your Medi-Cal policy is cancelled during the course of your treatment with Phys Med, you will be financially responsible for the services rendered.

MVA/PRIVATE INJURY – As a courtesy, Phys Med will bill YOUR auto insurance policy if you have med-pay coverage. We do not bill 3rd party liability. Please note, that you are responsible for the charges incurred regardless of "who's at fault". We can bill your health insurance, which may have an out of pocket expense to the patient.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize Phys Med Physical Therapy to furnish information to insurance carriers and assign Phys Med Physical Therapy all payments for services rendered. I have read and understand the financial agreement and responsibility whether or not covered by insurance.

CANCELLATION/NO SHOW POLICY

If you are unable to keep your appointment, please notify us at least 24 hours in advance. We will make every attempt to re-schedule your appointment. **At our discretion you may be charged a fee of $25.00 if you fail to show for your appointment.** If cancellations and now shows become excessive (3 maximum), we will remove you from the schedule and you will be put on a "call in" basis, which you will need to call in the morning you wish to be seen. All cancellations and no-shows are documented in your medical record.

Patient/Guardian Signature	Print Patient/Guardian Name	Date

PHYS MED PHYSICAL THERAPY
ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that Phys Med has offered and will provide a copy of its Notice of Privacy Practices upon request. This notice explains how your health information will be handled. HIPAA, a federal law concerning medical privacy requires this notice.

Phys Med has given me the opportunity to ask any questions about this notice and all questions have been answered.

_____ _____

Patient Signature or Responsible Party (if patient is minor) Date

****

Provider Use: If patient was not able to sign for any reason, or declined to sign, please document that the patient was given the notice and state the reason why the patient declined to sign.

Patient was given HIPAA notice YES NO

Reason signature was not obtained_____

_____

_____ _____

Staff Signature Date

AUTHORIZATION TO RELEASE INFORMATION

Phys Med will not disclose any information regarding your treatment with our company other than to your insurance carrier(s), your referring physician and to you, the patient. Keep in mind we cannot discuss any information with a significant other, spouse, children, caregiver, etc. If you wish to grant Phys Med such authorization to release any information regarding your treatment, please list those individuals and or company names.

_____ _____

Relationship to patient

_____ _____

Relationship to patient

_____

Patient Signature or Responsible Party (if patient is a minor)

Health History Questionnaire-Confidential

Name: _____ **DOB:** _____

Primary Care Physician: _____

Please complete this form as best you can. Your therapist can answer any questions you may have during your evaluation.

Please *circle* YES or NO for the following questions...

***For Women:* Are you currently **pregnant**? Yes No *(if yes) due date:* _____

- Are you currently **employed**? Yes No **Student** **Disabled**

(if yes) Job Title: _____ Any Work Restrictions: _____

- Are you currently involved in any **extracurricular activities or sports**? Yes No

(if yes) please list: _____

- Are you currently taking any **medication?** Yes No

(if yes) please list: _____

- Are you **allergic** to any medications, products or substances? Yes No

(if yes) please list: _____

- Have you had any **surgeries** or been **hospitalized** in the past? Yes No

(if yes) please list: _____

- Do you *currently* have any **open wounds, scabs or abrasions**? Yes No

(if yes) please list: _____

- Have you *ever* had a **broken bone**? Yes No

(if yes) please list: _____

Health History-Have you had any of the following? Please X that apply.

	yes	no		yes	no
Anemia			Heart attack		
Arthritis			Heart disease		
Asthma			Joint or bone problems		
Blood disorder			Neck or back pain		
Cancer			Liver/gall bladder		
Chest pain			Kidney disease/stones		
Diabetes			Rheumatic fever		
Epilepsy			Seizures		
High blood pressure			Thyroid problem		
Headaches/migraines			Ulcers		
High cholesterol			Other:_____		

_____ _____

Patient *or* Legal Guardian Signature **Date**