PATIENT REGISTRATION

Today's Date ____/____/_____

PATIENT INFORMATION

*Please Provide Your **PHOTO ID** to Receptionist*

First Name_____________________________ MI_______ Local Address __________________________________Apt.________

Last Name_______________________________________ City ___________________________________ST______Zip_________

Sex: ☐ M ☐ F **DOB**_____/______/______ E-Mail ____

Marital Status: ☐ Married ☐ Single Local Phone (_____) _________________________________

☐ Divorced ☐ Widowed Work Phone (______) _________________________________

(Check ONE) ☐ Employed ☐ Retired ☐ F/T Student Primary Physician ____

☐ Other ____ Referring Physician ____

Employer____ Employer Address____

GUARANTOR / RESPONSIBLE PARTY **(PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT)**

Name ____ Phone (______) ________________________

Last first middle

Sex: ☐ M ☐ F **DOB**____/_____/_____ E-Mail ____Relationship to patient__________

Address ____

Street City State Zip

PRIMARY INSURANCE INFORMATION

*Please Provide Your **INSURANCE CARDS** to Receptionist*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other_____________________________________

Insurance Company____

Primary Subscriber:____ Relationship to patient ___________________________

Address ____ **Phone (____)** __________________

ID #:_____________________________________ Group #__________________________ Subscriber's - DOB______/______/______

SECONDARY INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other_____________________________________

Insurance Company____

Primary Subscriber:____ Relationship to patient ___________________________

Address ____ **Phone (____)** __________________

ID #:_____________________________________ Group #__________________________ Subscriber's - DOB_____/______/______

WORKER'S COMPENSATION INFORMATION .

TYPE OF ACCIDENT: ☐ Auto ☐ Work ☐ Other (specify) __________________________________Injury Date____/_____/____

Company Name ____Company Phone (______) __________________

Claim/Case Number__________________ Claim/Case Manager____________________________________ Phone (_____) ___________

SSN: __________ -- ______ -- ___________

EMERGENCY CONTACT INFORMATION .

Contact Name______________________________________ Relationship _________________ Phone Number (_____) _____________

General Consent to Evaluate and Treat

Initials

______ I, undersigned, hereby give my consent to any diagnostic tests, work-up, or treatment as deemed necessary by my physician and/or ProFormance Physical Therapy and agreed upon in advance by me.

______ I hereby authorize ProFormance Physical Therapy to release all pertinent medical information/records requested by my insurance company(s). I hereby give consent that a copy of my medical records be sent to my primary and/or referral physicians(s).

______ I hereby understand that ProFormance Physical Therapy ProFormance Physical Therapy will charge $30.00, above and beyond the charges for services rendered, for any and all returned checks.

______ I hereby authorize payment directly to ProFormance Physical Therapy of the group insurance benefits specified by my insurance policy. I understand that I am financially responsible to ProFormance Physical Therapy for charges not covered by this authorization.

______ I hereby authorize ProFormance Physical Therapy to bill me directly for any co-insurance or deductibles due as stated in my insurance agreement. I further agree to pay for any and all charges **not** covered by my insurance plan.

______ I hereby allow ProFormance Physical Therapy to use my E-MAIL or mailing address to send me e-mail notices and newsletters as it pertains to physical therapy and fitness. Patient information is confidential and ProFormance Physical Therapy will **not** give out patient mailing or e-mail addresses to any outside entity.

______ I have read and understand the ProFormance Physical Therapy HIPAA policy. Any questions I may have had have been answered to my satisfaction.

INSURANCE COVERAGE/PAYMENT POLICY: Patients are expected to know their insurance benefits as applicable to physical therapy services. Patients are financially responsible for any applicable co-pay/deductible amounts as described in their health insurance patient policy manual. All co-pays/deductibles are due at time of service. Patients will be billed for any co-insurance/deductibles once insurance has processed claims, payment in full is expected and appreciated on or before due date listed on billing statement. Self pay patients must pay in full for services on the date the service is given. Payment arrangements, if necessary, must be approved by office manager prior to due date of first statement.

ATTENDANCE POLICY: Your rehabilitation plan and appointment schedule has been specifically designed to assure that you are able to achieve optimal benefit from your treatment program. Your regular attendance is critical to your success. We thank you for the courtesy of arriving on time for your scheduled appointments. You are encouraged to arrive at least 5 minutes before your scheduled appointment time. If you are late, we reserve the right to reschedule your appointment so as not to compromise the value of your appointment or that of others.

If you find it is necessary to cancel or reschedule an appointment for any reason we require that you contact us at least **24 hours** before your scheduled appointment to allow us to make necessary schedule adjustments for both you and our staff. **You may be charged $15 for any appointments that are scheduled and not attended – these charges will not be covered under your insurance benefits and must be paid prior to receiving further services. Additionally, any future scheduled appointments you may have will be cancelled and will need to be rescheduled by you and our front office staff.**

Thank you for choosing ProFormance Physical Therapy for your physical therapy needs. We appreciate your business and look forward to helping you achieve your therapy goals.

____

Patient Name (please **PRINT**)

____ ______________

Patient Signature *(If under 18 – Legal Guardian)* Date

How did you hear about us? ____