

Patient Registration

Today's Date: _____

Personal Information

Please Fill-Out Entire Form Completely & Legibly

Last Name

First Name

Age

Male Female

Street Address

City

State

Zip

() _____
Home Phone

() _____
Cellular

Email

Occupation

Employer Name

() _____
Employer Phone

Emergency Contact Person

Phone

(if minor) Parent/Guardian Name & Signature _____

My Condition is related to: Work Auto-Accident (State _____) Other _____

Social Security #: _____ Date of Birth: ____/____/____ Single Married

Work Status: Currently Employed Retired Disabled (____ Total or ____ Temporary) Student (__ PT __ F/T)

Referral Information

****ALL INFORMATION IS REQUIRED****

How did you hear about us?

Expo/convention Yellow Pages TV Radio Email

If you were referred by a friend, please provide their contact information below to allow us the opportunity to thank them with a note & a small gift.

Name _____

Phone () _____

Email _____

Primary or Referring Physician Name

Street Address

City

State

Zip

Phone

Fax

Email Address

Do you have a follow up appointment with this physician? YES NO

If so, when? ____/____/____

Payment Information

(Check only one box)

I'm paying by **CASH, CHECK, CREDIT** and would like a...

- 30% discount by paying at the time of service
- Payment plan. Fees may apply

I have **INSURANCE** and would like to...

- Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form." *Fees may apply.* The following information is required prior to the first visit.
My Coinsurance/Copay is \$ _____
My deductible is \$ _____
- Get a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own. (*Ask front desk person for details*)

I have an **ATTORNEY** and would like to...

- Get a 30% discount by paying up front. I'll get reimbursed after my case settles.
- Wait until my case settles before paying. I will complete the "Attorney Lien" Form.
Fees may apply.

I HAVE READ AND AGREE TO ALL OF THE POLICIES ON THE BACK OF THIS FORM.

Please Sign: _____

Important Company Policies

Please
Initial
All Boxes

We strive to provide you the best personalized care available and to do so requires your cooperation and understanding of a set of very important policies. Please read them carefully, initial all the boxes to indicate your agreement.

Late Policy "10-minutes"

If you are going to be more than 10 minutes late, we will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. In order to ensure the best care for all of our patients, we do not allow appointment overlap.

24-Hour Advance Notice Fee

We understand, things can come up- however, if you wish to change or cancel an appointment we do require a minimum of a **24-hour advance notice**. Anything less will result in a \$25.00 fee charged to your account. We do not charge you for the actual cost for that appointment, but we do require a small fee of \$25.00 to offset the financial costs we incur in an effort to make our office and staff available for you. In addition, advance notice allows someone else time to reserve an appointment in place of you.

Co pays are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment and the needed treatment you require.

No-Shows are not acceptable

If you fail to show for an appointment without notice, all future appointments will be forfeited and removed from our calendar and a \$25.00 fee will be assessed to your account. You may re-schedule appointments in the future on a "first come, first serve basis."

Please turn OFF your cell phone

We realize emergencies may arise and therefore you may carry your cell phone during your session, however, please be courteous and set it to silent mode or turn it off. Your cooperation is appreciated.

Alternate child care is recommended for children requiring supervision

In order to provide you with the dedicated and specialized care you deserve, we must limit distractions. We prefer you to make alternate arrangements for child care during your appointment for small children who require supervision. If your child is of the age he or she can be present without supervision by you or staff and is capable of waiting for you quietly, then it is perfectly acceptable to bring them with you. If a disturbance should occur and it causes distractions to other patients or staff members, we may ask you to terminate your session early and attend to your child.

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out and submitted to us for review. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. For assistance and more information, please ask our front desk person.

Important Notice from the Federal Government:

"It is unlawful to routinely avoid paying your co pay, deductible or coinsurance payments... even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's-Take what insurance pays." Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPPA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202-619-0089."

We look forward to building a relationship with you that will last a lifetime!

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance plan.



1. Benefit Info

What is your deductible amount? \$_____ and Coinsurance %_____ (for the services you are seeking)

If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.

If you have a coinsurance or unmet deductible give your credit card info here. Nothing will be charged unless a balance due.

Credit Card Type: _____ Exp. Date _____ Card #: _____

2. Policy Info

Patient Name: _____ ID # _____ DOB _____

Insurance Policy #: _____ Group # _____

Insured Name (if other than patient): _____ Insured Date of Birth _____

Your relationship to the Insured: Parent Spouse Other: _____

Claim # _____

I hereby instruct and direct _____ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider info:

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

Signature of Policyholder

Witness

Signature of Claimant, if other than Policyholder

FINANCIAL POLICY

Thank you for choosing Achieve Results Physical Therapy as your physical therapy provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy, which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the therapist.
- All applicable co-pays deductibles, personal balances, both current and prior, are due at time of service unless other arrangements have been made.
- We accept cash, check or credit cards.

Credit Card Payment Authorization

I understand that I can use my credit card to pay for any therapy related services. My signature below authorizes Achieve Results Physical Therapy to charge my credit card for any current or past due personal balance(s).

Card Number Expiration Date: _____ / _____

CVV Code _____ Billing Address: _____ City: _____ Zip: _____
(Last three digits back of card)

Name as it appears on Card: _____ Signature: _____

Regarding Insurance

We participate in numerous insurance plans. For most insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be *personally* liable for the balance not covered by insurance. Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company. We will work with you to determine the extent of your insurance coverage and payment options. In cases of financial need and other circumstances, billing adjustments may be an option.

Co-Pay Balances

Payment of co-pays and applicable deductibles are expected at time of service. Co-pays and deductibles are *not* covered by insurance. In some cases we will make exceptions to this policy. In the event that an exceptions is made for your specific situation, you will be provided with a **Financial Terms Agreement** that outlines your financial obligation as agreed upon by you and Achieve Results Physical Therapy. However, regardless of any terms outlined in the Financial Terms Agreement, you still agree to the terms listed below under Past Due Accounts.

Past Due Accounts

A DELINQUENCY CHARGE OF 1 1/2% PER MONTH, WHICH IS AN Annual Percentage rate of 18%, will be imposed on any amount remaining unpaid more than 60 days after the initial billing or a minimum monthly fee of \$1.00.

In the event of default or non-payment in whole or in part, the undersigned agrees that Achieve Results Physical Therapy shall be entitled to recover any and all collection expenses, which will be added to the outstanding bill before it is turned over to a collection agency, and agrees to any and all other collection expenses including court costs and reasonable attorney fees to secure payment of the amount in default.

An account will be determined to be in default if not paid within 60 days of the first statement date or if payment arrangements have not been made and acted upon within 60 days of the first statement date.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a \$25.00 fee.

I have read the Financial Policy and I agree to the terms and conditions outlined within this policy. Furthermore, I agree to assign all health insurance benefits directly to Achieve Results Physical Therapy.

Print Name

Signature

Date

New Patient Evaluation



What are you being seen for today? _____

When did this current episode begin? _____

Have you ever had this pain/problems before? _____

Was your chief complaint caused by an injury or following surgery? If so, please describe the injury or surgery:

Are your symptoms: Constant Intermittent

Are your symptoms: Better Worse Same

Do you have any numbness/tingling? Yes No

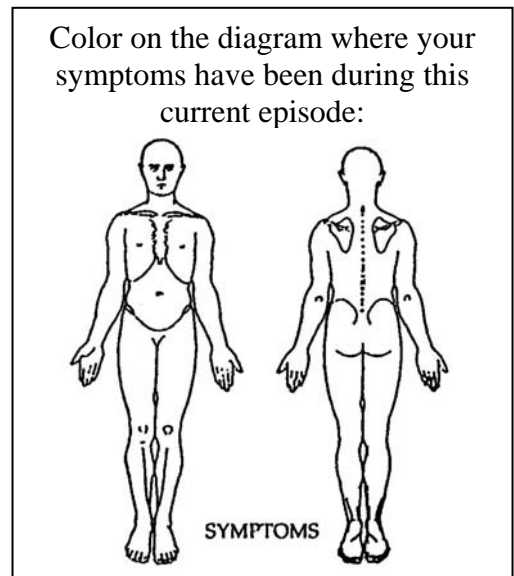
Pain on a Scale of 1-10 (10=worst): _____

Previous Related Injuries, Surgeries or Problems:

For this problem, have you had any special tests:

X-Rays CT Scan MRI EMG

Other: _____



Have you tried any other treatment? (heat, cold, chiropractic) Did it help?

Do you have: Diabetes Pacemaker Cancer Other: _____

Do you have any allergies to: Latex Steroid Medicines Other: _____

What medications are you currently taking?

Females: Is there any chance you could be pregnant? Yes No

What job duties/positions at work flare up your symptoms?