PREMIER PHYSICAL THERAPY

Registration Form

Date: _______________

☐ Male ☐ Female

______________________________ ______________________________
Last Name First Name M.I.

____________________________________ _________________________ ________ ____________
Street Address City State Zip Code

(___)________________ (____)____________________ ________________________________
Home Phone Cellular Phone Email Address

__________________________ ______/_______/______ ☐ Single ☐ Married ☐ Widowed ☐ Other
SSN or Driver's License # DOB

_______________________ ___________________________ (_______)__________________
Occupation Employer Phone

_________________________ (______)__________________ ____
Emergency Contact Phone If patient is a minor, Parent/Guardian Signature Here

Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled (☐ Temporary ☐ Total) ☐ Student (☐ PT ☐ FT)

What caused your pain? ____

☐ AUTO / PERSONAL INJURY: Date of Accident _____/______/______

☐ WORK INJURY: Date of Injury: ______/_______/_______
Insurance Adjuster Name: ________________________________ Insurance Adjuster Phone: (____) ___________________________

Health Information: Current Medications & Dosages (including vitamins/supplements) or ☐ copy attached

Health Condition(s): ____

☐ SURGERY Please describe (include dates):

____

____

☐ PHYSICAL THERAPY (when and where) :

____

☐ HOME HEALTH CARE/HOSPICE: Are you still receiving care? ☐ YES ☐ NO

☐ Other care:

____

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Informed Consent for Treatment

The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I ______________________________ (patient), consent to rehabilitation treatment as prescribed by my provider.

_______________________________________ _____________________

Signature **Date**

General Patient Policies

Do not be late. If you are more than 10 minutes late to your appointment, you may be asked to reschedule, and a $40 fee will be applied to your account.

Give 24-hour advance notice. A $40 fee will be automatically applied to your account for any reschedules or cancellations made with a less than 24-hour advance notice. A $40 fee will also be automatically applied for any **NO SHOW**.

Please silence or turn off your cell phone.

No unlawful waiver of patient responsibility payments. Outside of documented financial hardship (federal guidelines used) no waiver, discounts, or special treatment will be awarded.

Please sign below acknowledging that you have read and understand the above policies.

______________________________________ ___________________

Signature **Date**

Statement of Privacy Notice

I understand that Premier Physical Therapy may use and disclose my protected health information for purposes of treatment, research, payment, and health care operations. I also acknowledge that I have asked, received, or have received in the past, a copy of the practice's Notice of Privacy Practices, which provides information about how the practice, and individuals involved in my care in the practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand I can contact Premier Physical Therapy at 540-785-9770.

__________________________________ ______________________

Signature **Date**

Medical Information Release Form

(HIPAA Release Form)

Name: ___________________________________ Date of Birth: _____/____/_____

Release of Information (please check the appropriate boxes):

I authorize the release of information including the diagnosis, records;

examination rendered to me and claims information. This information may be released to:

[ ] Physician(s)____

I also authorize the above mentioned physician(s) to release information including records, diagnostic reports,

and examination notes to Premier Physical Therapy.

[ ] Spouse____

[ ] Child(ren)____

[ ] Other____

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell __________________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (day)___________________ between (time)_________

Signature: ______________________________________ Date: ____/____/_____

Authorized Signature of Facility: ______________________________________ Date: ___/____/______

6330 Five Mile Centre Park Suite 406 Fredericksburg VA 22407 Phone: (540) 785-9770 Fax: (540) 785-9772
7951 Kings Highway King George VA 22485 Phone: (540) 625-2311 Fax: (540) 625-2275

Assignment of Benefits to Premier Physical Therapy

Patient Name: ____

Insurance ID#('s) ____

Subscriber Name: _________________________ Subscriber Date of Birth: _______________

Your relationship to the Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Employee ❑ Other

I hereby instruct and direct ____
insurance company/companies to pay by check made out and mailed to:

Premier Physical Therapy
6330 Five Mile Centre Pk #406
Fredericksburg, VA 22407
540-785-9770

If my/this current policy prohibits direct payment to the provider and will only mail payment to my address on file with the insurance company, I will either sign the check over to Premier Physical Therapy or deposit the funds into my account and write a check to Premier Physical Therapy for the amount owed.

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.

- 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 Premier Physical Therapy to deposit checks made in my name.
- I authorize Premier Physical Therapy 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 paid by insurance and if I fail to make payments on my account, it will be transferred to a collection agency.

Date: _____________________ 20_____.

__________________________________ ____________________________
Signature of Policyholder Witness

____
Signature of Claimant/Dependent, if other than Policyholder

PREMIER PHYSICAL THERAPY

VERIFYING YOUR INSURANCE BENEFITS

(*Not required* for patients who are filing under: Medicare, Worker's Compensation, Department of Veterans Affairs, Self pay patients, Medpay with Auto Insurances or have a signed lien from a law office.)

Name: ______________________________

Prior to your appointment, we ask that you contact your insurance company to verify your physical therapy benefits. Check for the toll-free number on the back of your insurance card and either speak with a representative or use the automated system to find out your:

Co-pay per visit ____________________

Deductible ________________________ Deductible Met___________________

Co-insurance ______________________ Out of pocket expense__________________

Do you require prior authorization or a referral? _____________

(**ALL TRICARE PRIME POLICIES REQUIRE AN AUTHORIZATION INITIATED BY YOUR PRIMARY CARE DOCTOR.** Please allow three to five days between requesting this authorization and scheduling your first appointment.)

Visit limitations ___________________ Monetary limitations _____________________

Do your benefits run on a calendar year? Or benefit/service year: _______ to _______?

If you are coming under Direct Access, verify if your insurance will cover your visit without a physician's prescription.

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Fredericksburg, VA 22407

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King George VA 22485

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WEB SITE www.mypremierpt.com
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