Patient Registration

Patient Name: ______________________________Social Security #: ___________________________

Street Address: ____ Date of Birth: ______________

City, State & Zip: ____ Male/Female

Employer: ____ Employer Phone: ________________

Phone #'s: Home: _________________________________ Cell: _______________________________

Spouse Name: _______________________________ Social Security #: _________________________

Date of Birth: _____________ Employer: ______________________ Employer Phone: ___________

Is it ok to send appointment reminders via email? Yes/no.

If yes, Email address:____

Referring Doctor: __________________________Primary Care Doctor: ________________________

Is this injury due to an accident? No______Yes:________Auto______Work_______Personal______

If yes, date of injury:______________________________Is an Attorney Involved? No_____ Yes ____

If yes, Name of Attorney & phone #____

Primary Insurance Co._________________________________ ID#:____________________________

Subscriber's Name:___________________________________their D.O.B.______________________

Secondary Insurance Co. ._____________________________ ID#:____________________________

Subscriber's Name:____________________________________their D.O.B.______________________

Have you had Physical Therapy this year? No __Yes__Where_________________________________

Emergency Contact, Name:_____________________________Relation:________________________

Phone #s: Home_________________Work_ ___________________Cell________________________

Emergency Contact, Name:_____________________________Relation:________________________

Phone #s: Home_________________Work_ ___________________Cell________________________

Consent

Patient's Name: ____

Consent to Physical Therapy Evaluation and Treatment: I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by Purpose Physical Therapy. The physical therapist will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment. I specifically give my permission for continued procedures and tests on a recurring or on an as needed/as individually ordered basis. I understand that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure.

Minor Patients: The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient and financial responsibility forms.

Patient Information Consent Form (HIPAA): I understand that Purpose Physical Therapy may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Purpose Physical Therapy will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes necessary for the therapy provided by Purpose Physical Therapy. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Purpose Physical Therapy has 30 days to respond to my request.

Assignment of Benefits and Insurance Proceeds: I authorize payment of medical benefits to Purpose Physical Therapy for services rendered. Purpose Physical Therapy will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Release of Information:
I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Collections: If your account becomes delinquent, collection proceedings will occur, and you will be 100% liable for any collection fees, attorney and court costs incurred by Purpose Physical Therapy to collect said fees from the Responsible Party.

Returned Checks/Liens: Returned checks are subject to a $25.00 administrative charge as well as the bank's charge for bounced checks. Any liens will be subject to a $20.00 co-payment for each visit. In addition, the account will incur a 1.5% interest charge for balances >30 days.

No Show/Cancel/Late Policy: Cancellations with less than 24 hrs notice will result in a $20.00 fee. Cancellations with less than 12 hrs notice, or no notice will result in a $30.00 fee.

I HEREBY ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE RESULT OF TREATMENT OR SERVICES PROVIDED OR TO BE PROVIDED TO ME. I CERTIFY THAT HAVE READ THE ABOVE AGREEMENT (OR IT HAS BEEN READ TO ME) AND I UNDERSTAND WHAT IT SAYS. MY QUESTIONS WERE ANSWERED TO MY SATISFACTION. I HAVE BEEN OFFERED A COPY OF THIS DOCUMENT. CERTIFY THAT AM THE PATIENT OR PERSON DULY AUTHORIZED BY THE PATIENT TO EXECUTE THIS AGREEMENT AND I AGREE TO ITS TERMS.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, ____________________________, have received a copy of the Purpose Physical Therapy Notice of Privacy practices.

Signature:____Date:_______________

Witness:____Date:_______________