PATIENT REGISTRATION FORM

Today's Date: _____

Location: ☐ Portsmouth ☐ Brentwood

Abilities
Physical Therapy & Wellness Center

Patient Information

Patient Name: _____ DOB: _____

Mailing Address: _____ SS#: _____

City: _____ ST: _____ ZIP: _____

Primary Phone: _____ H W C Secondary Phone: _____ H W C

Email: _____

Preferred method of contact for appointment confirmations: ☐ Email ☐ Text ☐ Call ☐ Please do not contact

Gender: M F Status: S M If Married, Spouses Name: _____

Under 18: Y N If Yes, Parent/Gaurdian Name & DOB: _____

Medical Information

Referred By: _____ Practice Name/Phone: _____

Primary Care Physician: _____ Practice Name/Phone: _____

Diagnosis: _____ Date returning to the Doctor: _____

Have you been seen by a chiropractor or physical therapist for this condition? Y N

If yes, how many visits and name of the provider: _____

Have you received out patient or home care within this calendar year for any reason? Y N

If yes, Company Name: _____ **Contact Name:** _____ **How many visits :** _____

Phone: _____ **Date of discharge:** _____

Work Co/Auto

Work Comp: Y N Auto Accident: Y N If Yes to Auto or Work Comp, please complete below

Employer: _____ Date of Injury: _____

Address: _____ Adjuster: _____

City: _____ ST: _____ ZIP: _____ Claim/Case#: _____

Primary Insurance

Insurance 1: _____ ID: _____ Group #: _____

Insurance Address: _____

☐ Subscriber ☐ Dependent* If Dependent, Subscriber Name: _____ DOB: _____

Effective Date: _____ Referral Required: Y N Pre Certification Required: Y N

Co Pay: _____ Coinsurance: _____ Deductible: _____ Met Deductible: Y N

Visit Max: _____ ☐ Per Cal Yr ☐ Per Member Yr $ Max: _____ ☐ Per Cal Yr ☐ Per Member Yr

Verified By: _____ Date Verified: _____

Secondary Insurance

Insurance 2: _____ ID: _____ Group #: _____

Insurance Address: _____

☐ Subscriber ☐ Dependent If Dependent, Subscriber Name: _____ DOB: _____

Effective Date: _____ Referral Required: Y N Pre Certification Required: Y N

Co Pay: _____ Coinsurance: _____ Deductible: _____ Met Deductible: Y N

Visit Max: _____ ☐ Per Cal Yr ☐ Per Member Yr $ Max: _____ ☐ Per Cal Yr ☐ Per Member Yr

Verified By: _____ Date Verified: _____

CONFIDENTIALITY/EMERGENCY CONTACT AGREEMENT:

We are unable to share information with any person other than the patient. Please list all those you give permission for us to discuss your medical

Name: _____ Relationship: _____ Phone: _____ Zip _____

Name: _____ Relationship: _____ Phone: _____ Zip _____

PATIENT NAME: _____ DOB: _____

Please initial on the line to the left of each section to show you understand and agree to the information provided.

____ **CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for **Abilities Physical Therapy** to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition.

____ **BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION**

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to **Abilities Physical Therapy**. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

____ **PRIVACY PRACTICE**

I, the undersigned, have read the privacy practice and give my consent to your use and disclosure of my health information.

____ **FINANCIAL POLICY STATEMENT**

1. **As a service to our patients, Abilities will verify your benefits with your insurance company. The provider is not always given a complete outline of your benefits. It is the patient's responsibility to be aware of their in-network/out of network options as well as the contractual agreement they have with their insurance policy and to initiate a referral when necessary.**
2. Our copays are due at the time of service. A $5 processing fee will be applied to all copays subsequent to that date of service. Pre-payments for copays are accepted.
3. Any returned check will be subject to a $25 processing fee. If a check is returned you will not be permitted to use this form of payment in the future.
4. If your check is dishonored or returned for any reason when you pay by check, you expressly authorize Abilities Physical Therapy to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit. Please note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that Abilities Physical Therapy cannot collect a returned check fee by other methods.
5. Any appointments cancelled with less than 24 hours notice will be assessed a $25 cancellation fee. This includes no-shows.
6. Coinsurance and deductible amounts are due directly after processing through the medical insurance provided to our practice.
7. Abilities also accepts CareCredit. This can be used for ongoing treatment, with no upfront costs, no annual fees, and no pre-payment penalties. You may apply for CareCredit in person at our office, or online at www.carecredit.com. See our administrative staff for more details.
8. Any outstanding balances that are past due will be assessed a $10/month processing fee. Outstanding balances that are not responded to and are older than 60 days with at least three statements billed may be forwarded to a collection agency. The $10/month processing fee will continue to be assessed.
9. **Patients MUST immediately report to us any changes to their insurance plans. Any denials in services already provided as a result of failing to report changes will be the financial responsibility of the patient.**
10. Although we make every effort to assist our patients in dealing with the insurance companies, we cannot serve as negotiators of your contract with them. Ultimately, it is the patient's responsibility to resolve any insurance denials directly with their insurance company when the denial is through no fault of our practice.
11. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit it to Abilities PT.
12. The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim WC benefits and are subsequently denied, you may be held responsible for the total amount of charges for services rendered to you.
13. I understand and agree that if I fail to make any of the payments for which I am obligated, I will be also be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.
14. Patient understands that any unsettled balances from a previous case must be resolved prior to returning for care.

_____ **ESTIMATED RESPONSIBILITY:** Co Pay: _____ Coinsurance: _____ Deductible: _____

I understand this amount is only an estimate and listed as a courtesy. I am responsible for knowing my benefits.

I have read and understand the above information. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

PatientSignature or Guardian/Responsible party **Date**

_____ _____

Center Representative Signature/Witness **Date**