Regional Physical Therapy
REGISTRATION FORM

PATIENT INFORMATION

Patient's Name First:	M.I.:	Last:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Preferred Method of Appt Reminders: [ ] Home Phone [ ] Cell Phone [ ] Text [ ] Email [ ] Check Here For No Appt Reminder			
Social Security Number: - -			
Date of Birth:	Gender: **Unspecified**		
Date of Injury:	Place (State) of Injury:		
Attorney Name:	Phone : ( )		
Emergency Contact:			
Relationship:	Phone: ( )		
Home Health in the past year? [ ] NO [ ] YES			
YES Name of Home Health Agency:			
Phone: ( )	Date of Discharge?		
How did you hear about our clinic? [ ] Patient/Friend/Family Referral [ ] Return Patient [ ] Website [ ] Phone Book			
Doctor Referral: **Dr.**			
Other:			

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD

Primary Insurance Company:		ID #:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other		
Employer:	Work Phone:	
Secondary Insurance Company (If Applicable):		ID #:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: (Circle One) Self / Spouse / Minor / Other		
Employer:	Work Phone:	

GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)

Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Relationship to Subscriber: (Circle One) Self / Spouse / Other	Date of Birth:		
Employer:	Work Phone:		

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Regional Physical Therapy and hereby authorize and give my consent for RPT to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for Regional Physical Therapy to treat _____ (minor's name) while I am not present.

Patient / Guardian / Responsible Party Signatur		**Date:**

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

PATIENT INFORMATION CONSENT: I have read and fully understand Regional Physical Therapy's Notice of Information Practices. I understand that RPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that Regional Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Regional Physical Therapy's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Initials

ATTENDANCE, CANCELLATION, and NO SHOW: Your adherence to the recommended number of treatments is a vital component of your progress with our services. It can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least 24 hours' notice of cancellation. There is a $25 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

_____
Initials

FINANCIAL RESPONSIBILITY: As a courtesy to you, Regional Physical Therapy will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. RPT is not responsible for issues between the patient and insurance carrier, nor can RPT intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, RPT requires payment by the patient for any equipment/supply at the time the order is placed. RPT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. RPT accepts cash, visa, mastercard, or discover as payment options.

_____
Initials

We strive to provide our patients with the utmost professionalism and excellence to service our commitment to your wellbeing and gain of your physical abilities is something everyone at RPT takes quite seriously. If you don't feel you are getting the care you need or want, please talk to your immediate therapist. If you don't feel they are listening or don't feel comfortable talking with them, please talk with an advocate in the reception area.

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hearby authorize RPT to share any and all of my medical / billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

PATIENT AUTHORIZATION

- By my initials and signature I understand these policies and my financial obligations for services rendered.

- I hereby assign payment of benefits by my insurance company to Regional Physical Therapy, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.

- I hereby agree to pay any office visit/co-payment charges at time of visit.

- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ **Date:** _____

Parent / Guardian / Guarantor: _____ **Date:** _____