

Today's Date: _____

Rev 12/18/19

PATIENT REGISTRATION

<i>PATIENT INFORMATION</i>			
Patient Name:			
First: _____	M.I. _____	Last: _____	Gender: M / F
DOB: ____/____/____	SS #: - -	Marital Status: _____	Student: Yes / No
If the patient is <u>minor</u>, enter the address for the legal guardian or guarantor			
Address: _____		City: _____	State: _____ Zip: _____
Home Phone: () _____	Cell Phone: () _____	Work Phone: () _____	
Email Address: _____			
Employment Status: Full-Time / Part-Time / Retired / Student / Self-Employed / Disabled			
Occupation: _____		Employer: _____	
Employer Address: _____			
Emergency Contact: _____		Phone: () _____	Relationship: _____
Legal Guardian or Guarantor Information:			
First: _____	M.I. _____	Last: _____	Relationship to patient: _____
DOB: ____/____/____	SS #: - -	Gender: M / F	
<i>MEDICAL INFORMATION - This section must be completed</i>			
Injury Due To (please circle) : Work (State) Auto (State) Accident Other			
Date of Injury/Surgery/Symptoms: ____/____/____			Body Part: _____
Referring Physician Last Name: _____		First Name: _____	Phone: _____
Referring Physician Address: _____			
Primary Care Physician: _____			
Have you had any Home Health or therapy elsewhere in the current year? Yes No Where:			
<i>INSURANCE INFORMATION</i>			
Insurance Type - Circle one: PPO HMO POS MEDICARE AUTO WORK COMP OTHER			
Primary Insurance :		Policy/Claim #:	Group #:
Policy Holder:		Policy Holder DOB:	
Policy Holder Relationship to Patient:		Policy Holder Employer:	
Secondary Insurance:		Policy/Claim #:	Group #:
Policy Holder:		Policy Holder DOB:	
Policy Holder Relationship to Patient:		Policy Holder Employer:	
<i>WORK COMP OR AUTO ONLY</i>			
Case Manager / Adjuster Name: _____		Phone: _____	Fax: _____
Have you submitted any claims to PIP, including lost wages? Yes / No Lost time from work due to accident? Yes / No			
Dollar amount of PIP Available** _____			
** IF YOU DO NOT KNOW THE AMOUNT OF PIP AVAILABLE, PLEASE CONTACT YOUR INSURANCE COMPANY **			

Patient Name:		
First:	M.I:	Last:

ATTORNEY INFORMATION

Attorney Name: _____ Phone: _____

Address: _____

HIPAA ACKNOWLEDGEMENT – ALL patients must initial one of the following:

_____ I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices

_____ I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices, but decline to accept it at this time

Acceptable Method of Contact: ___Home ___Cell ___Work ___Email

Do you give permission for us to leave a message: ___Yes ___No

CANCELLATION & NO SHOW

It is expected that you actively participate in the recovery process and give 100% effort toward the goals established by you, your therapist and your doctor. Your attendance is critical to the success of your program, therefore, missed appointments may be reported to your physician, insurance carrier, employer, and vocational counselor. Additionally, if you fail to show for a scheduled visit or to reschedule any visit within 24 hours prior to the scheduled time, you may be charged a \$40.00 No Show/Cancellation fee.

_____ I hereby acknowledge that I have read and understand the above statement regarding the No Show/Cancellation Fee

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

I hereby authorize Mady and Mules Physical Therapy to administer treatment required for my diagnosis, to apply for benefits from my insurance carrier(s) listed able, and I authorized payment of the medical benefits directly to Mady and Mules Physical Therapy. Further, I authorized Mady and Mules Physical Therapy to disclose complete medical information concerning the diagnosis for which I am being seen to any other payer or collateral that will pay part or all of these medical bills.

I also understand that it is my responsibility to know my insurance benefits and coverage limitations and will be responsible for any service that my insurance carrier does not cover.

I understand that all financial obligations for services are due from me when treatment is rendered. I also understand that I am completely responsible for medical treatment, including any fees charged for returned checks, regardless of any payer, third-party interest, or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Mady and Mules Physical Therapy reserves the right to pursue delinquent accounts via third -party collection agencies or attorneys. In the event my bill is referred for collection, I agree to pay all collection agency fees, attorney fees, court costs, service of process fees and any late charges per month for all balances over 30 days, in addition to the amount owed for services rendered (as applicable by state guidelines). I understand that by providing my landline or cell phone number(s), I give my consent for Mady and Mules Physical Therapy, its agents, and its collection agents, to contact me at these numbers, or, at any number that is later acquired for me, and, to leave live, or pre-recorded messages regarding any accounts, or services.

MADY AND MULES PHYSICAL THERAPY IS NOT RESPONSIBLE FOR ANY PERSONAL ITEMS WHILE TREATMENT IS BEING RENDERED OR FOR ANY ITEMS LEFT OR LOST IN THE FACILITY.

Thank you for giving us the opportunity to serve you. Please feel free to ask us any questions about our services, policies and fees.

Signature of Patient or Responsible Party	Relationship to Patient	Date
_____	_____	_____