Howard County
Physical Therapy Sports Rehabilitation

Today's Date: _____ Rev 12/18/19

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name:

First: M.I. Last: Gender: M / F

DOB: _____/_____/_____ SS #: - - Marital Status: Student: Yes / No

*****If the patient is minor, 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

MEDICAL INFORMATION - This section must be completed

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:

INSURANCE INFORMATION

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:

WORK COMP OR AUTO ONLY

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 ****

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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 Howard County Physical Therapy (HCPT) 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 Howard County Physical Therapy (HCPT). Further, I authorized Howard County Physical Therapy (HCPT) 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 Howard County Physical Therapy (HCPT) 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 Howard County Physical Therapy (HCPT), 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.

HOWARD COUNTY PHYSICAL THERAPY (HCPT) 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**
_____	_____	_____