ADAPT PHYSICAL THERAPY

Patient Registration

Todays Date:

PATIENT INFO

Please Fill-Out Entire Form Completely & Legibly

Last Name	**First Name**	**MI**	**Nickname**
Mailing Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Work Phone**	
Date Of Birth	**Social Security Number**	**E-Mail**	
Employer	**Address**	**Employer Phone**	
Parent/ Spouse Name	**Parent/ Spouse Employer**	**Parent/ Spouse Phone #**	
Emergency Contact	**Phone Number**		

My Condition

My injury/ ailment is related to…

❑ AUTO/ PERSONAL INJURY : Date of accident:___/___/___

❑ WORK INJURY : Please complete all information below.

Date of accident:___/___/___

Your company HR person name_____

Work Comp Adjuster name_____

Adjuster Phone # _____

❑ NO INJURY: What do you think may have caused it?

I have already had…

❑ SURGERY: When and what type

❑ PHYSICAL THERAPY: When and where?

❑ HOME HEALTH CARE: Are You still receiving it?

❑ OTHER CARE: Please describe…

PAYMENT INFO

I am paying TODAY by….(Check One Box)

❑ INSURANCE: and would like to…

___ Have you bill them directly. I will assign my benefits to ADAPT and also agree to pay my ESTIMATED Deductible/ Coinsurance as outlined on the attached "Assignment of Benefits"

❑ WORKERS COMP: Info must be provided under "MY CONDITION"& "Assignment of Benefits"

❑ CASH, CHECK, CREDIT: and would like a…

___ Payment plan (upon approval)

❑ CARE CREDIT

❑ I HAVE AN ATTORNEY: and would like a…

___ Wait until my case settles before paying. I will complete the "Attorney Lien" form

REFERRAL INFO

❑ Friend/ Family member ❑ Social Media ❑ Physican/ Chiropractor/ Nurse:_____

❑ Internet/ Website ❑ Insurance Co City, State_____

❑ Advertisement ❑ Other: Phone Number _____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing the bottom of this form.

☐ **Copays are due upon arrival**
I you happen to forget your wallet or checkbook, we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **Important Notice from the Federal Government**
It is unlawful to routinely avoid paying your copay, deductible, or coinsurance payments, even if our doctor allows it. Unless you complete a Financial Hardship Form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan, even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and TWIP's – Take what insurance pays. Failure to comply places you I violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 section 231(h) of HIPPA. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-260-8512, by email: p0affairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Human, Room 5541 Cohen Building 333, Independence Ave. SW, Washington, DC 20201, Joel Schaer, Office of Counsel to the Inspector General, 202-616-0089.

Patient (If Minor, Guardian) Signature_____

Date_____

_____

Assignment of My Benefits

IMPORTANT: All Information must be **completed** or we will not be able to do the courtesy of billing your insurance plan directly

Benefit Info

What is your deductible amount? $_____ Coinsurance %_____ or Copay amount per visit? $_____

(If you are unsure, you can contact your insurance company using the toll free number on the back of your insurance card)

Policy Info

Patient Name_____ DOB_____

Subscriber Name_____ DOB_____

Insurance Company_____
ID#_____ Group#_____ Ph#_____

Your relationship to insured?_____

For MVA or Work Comp Claim, please provide claim #_____

I authorize ADAPT Physical Therapy to render treatment, as it/ they determine necessary, to me/ my dependant. I understand that I will be given all pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and to have them answered. I understand I may decline treatment at any time.

I authorize ADAPT Physical Therapy to bill my health insurance for services rendered. All payments received will be applied to my balance. I will be responsible for all co-pays/ coinsurance and deductibles that may apply. I understand that ADAPT Physical Therapy will bill my insurance as a courtesy to me but not as an obligation. Although ADAPT Physical Therapy will help to verify and assist in understanding my benefits, it is ultimately my responsibility and I will not hold ADAPT Physical Therapy responsible for any misunderstanding or misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are due and payable by me.

MEDICARE PATIENTS ONLY – I authorize payment of Medicare benefits to ADAPT Physical Therapy for services rendered and I authorize release of medical information to the Centers for Medicare and Medicaid Services.

This is a direct assignment of my rights and benefits under this policy

❑ A photocopy of this assignment shall be considered as effective and valid as the original.

❑I authorize the release of any medical or other information as pertinent to my case to any insurance company adjuster, attorney involved int his case for the purpose of processing claims and securing payment of benefits

❑I authorize the use of this signature on all insurance submissions

❑I authorize ADAPT Physical therapy to deposit checks made in my name

❑I authorize ADAPT Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf

❑I understand that I am financially responsible for all charges, whether or not paid by insurance

Dated this_____ day of _____, 20___

_____ _____

Signature of policy holder Signature of Patient/or guardian(if different than policy holder)