REGISTRATION FORM
(PLEASE PRINT OR TYPE)

Today's Date: ______/______/______	Referring Physician:		
Patient's Last Name:	First:	Middle:	
Phone #:	Email:		
Birth Date: ______/______/______	Sex: ☐ Male or ☐ Female	Age:	
Home Address (street):	City:	State:	Zip:
Occupation:	Employer:	Employer Address:	Employer Phone #:

How did you hear about us?

☐ Medical Provider ☐ Family/Friend ☐ Website ☐ Insurance ☐ Google ☐ Social Media

INSURANCE INFORMATION

Is this patient covered by insurance? ☐ YES or ☐ NO

Name of Primary Insurance:	Group #:	Policy #:
Policy Holder/Subscriber's Name:	Subscriber's Social Security Number:	Subscriber's Birth Date: ______/______/______

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Subscriber's Address:	Subscriber's Phone #:		
Subscriber's Occupation:	Subscriber's Employer:	Subscriber Employer's Address:	Subscriber Employer's Phone #:

REGISTRATION FORM (cont.)			
Name of Secondary Insurance:	**Subscriber's Name:**	**Group #:**	**Policy #:**

IN CASE OF EMERGENCY			
Contact Name:	**Relationship to Patient:**	**Primary Phone #:**	**Secondary Phone #:**

VERIFICATION AND AUTHORIZATION

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to PRIME Physical Therapy. I understand that I am financially responsible for any balance. I also authorize PRIME Physical Therapy or the insurance company/companies listed in this form to release any information required to process my claims.

Patient/Guardian Signature Date

Health History Form

Name:	**Date:**
Email:	

Please check YES or NO

Have you or any immediate family member ever been told you have:

	Yourself YES	Yourself NO	Family YES	Family NO
Cancer?	☐	☐	☐	☐
Diabetes?	☐	☐	☐	☐
High blood pressure?	☐	☐	☐	☐
Heart disease?	☐	☐	☐	☐
Chest pain?	☐	☐	☐	☐
Stroke or TIA?	☐	☐	☐	☐
Osteoporosis?	☐	☐	☐	☐
Osteoarthritis?	☐	☐	☐	☐
Rheumatoid arthritis?	☐	☐	☐	☐
Head/neck trauma?	☐	☐	☐	☐

In the past 3 months, have you had, or do you experience:

	YES	NO
A change in your health?	☐	☐
Nausea/vomiting?	☐	☐
Fever/chills/sweats?	☐	☐
Unexplained weight loss?	☐	☐
Numbness or tingling?	☐	☐
Changes in appetite?	☐	☐
Difficulty swallowing?	☐	☐
Bowel or bladder issues?	☐	☐
Shortness of breath?	☐	☐
Dizziness?	☐	☐
Upper respiratory infection?	☐	☐
Urinary tract infection?	☐	☐

Have you previously had any trauma to your head and neck (e.g., blunt trauma, fall, serious car accident, concussion, etc.)? YES NO
☐ ☐

If YES, briefly describe:

____

If YES, have you had any head or neck imaging performed since the event? YES NO
☐ ☐

Please check YES or NO

Do you have a history of:

	YES	NO
Allergies/asthma?	☐	☐
Headaches?	☐	☐
Autoimmune disease?	☐	☐
Blood-borne disease?	☐	☐

	YES	NO
Are you currently pregnant?	☐	☐

Are your current symptoms: (check ONE)
☐ Getting better ☐ The same ☐ Getting worse

How are you able to sleep at night? (check ONE)
☐ No difficulty ☐ Some difficulty ☐ Extreme difficulty

Do you have a problem with: (check ALL that apply)
☐ Hearing ☐ Vision
☐ Speech ☐ Communication

	YES	NO
Do you, or have you, smoked tobacco?	☐	☐

If YES, how many packs/day/week, and for how many years did you smoke? ______________________

Last tobacco use? ______________________

Date of last physical exam: ______________________

List ALL medications, vitamins, and supplements you are currently using:

____
____
____
____
____
____

PRIME
PHYSICAL THERAPY

Please describe the injury that you are coming in for today:

____

____

____

____

Date symptoms started: ____________________

Have you had surgery for this body part?

☐ **YES** ☐ **NO**

If YES, surgery that was performed:

____

Date of surgery: ____________________

Surgeon's name: ____________________

Have you previously had physical therapy for this injury?

☐ **YES** ☐ **NO**

If YES, how many sessions?

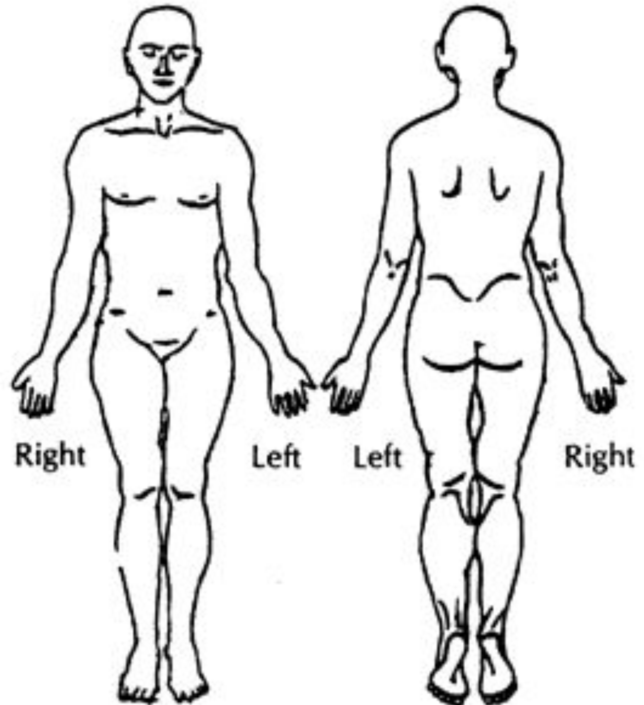
Do you have any other medical conditions that we should be aware of before initiating physical therapy? If so, please describe.

____

____

____

____



Please list any further questions or concerns that we should be aware of prior to treatment.

____

____

____

____

____

<u>Verification and Consent</u>

The above information is accurate to the best of my knowledge, and I consent to treatment by PRIME Physical Therapy, for this condition.

____

Patient/Guardian Signature Date

Informed Consent and Policies Agreement

Medical Necessity
All treatments must be justified and medically necessary in order for us to treat and bill your insurance.

Cancel/No-show/Late
Must give 24 hours notice for cancellation otherwise a $50 fee will be charged.

Results
The purpose of physical therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients
It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients
If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents
If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent
By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist about drugs or medications being taken as well as any medical conditions and/or surgeries. Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Videos and Pictures
We take pictures and videos in our clinic to be used on our website and social media accounts. Please let us know if you DO NOT consent to having your pictures on our online media.

Patient Declaration
The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

____
Patient Name (printed)

____
Patient Signature/Date

____
Witness Signature/Date

Statement of Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or health operations.

We may disclose your health information to your insurance provider for the purpose of payment of health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule.

We may contact you by phone, email, or mail.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by us.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions or complaints about any part of this notice or how your health information was handled, or if you want more information about your privacy rights, please contact us by calling this office at (443)-531-5888. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to:
200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting
www.hhs.gov/ocr/privacy/hipaa/complaints/.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide PRIME Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____

Patient name (printed)

____

Patient Signature

____

Authorized Facility Signature

Cancellation Policy/No-show Policy

Please provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to cancel an appointment for any reason will be charged a **$50.00** fee.

This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

Patient name___________________________

Signature______________________________ Date__________

Witness________________________________

Dear Patient,

Prime Physical Therapy has a policy that applies to all patients. We require a credit card (not a debit card) to be on file as a guarantee of payment for any patient responsible balance. This policy authorizes Prime Physical Therapy to charge your credit card for any patient responsible balance after insurance processing.

Copays will still always be collected at time of service. You will receive an email with your billing statement as well as a receipt for the payment transaction. You will receive a courtesy call before your card is charged for any patient balance greater than $400. If your credit card account is closed or your card has expired, please notify us as soon as possible. Declined transactions or closed credit card accounts without alternative method of payment may incur a $50 penalty.

Your insurance company will continue to send you an Explanation of Benefits (EOB) that explains how much your insurance paid and how much you are responsible to pay. Our new policy will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment. Your credit card information will be kept in compliance with all federal and consumer rules protecting and regulating the storage and use of this information (PCI SSC).

If you have a billing question, you can contact RevFlow at 855-873-4115.

We appreciate your cooperation in complying with our policy.

I authorize Prime Physical Therapy to charge my credit card any patient responsible balance on my account.

Patient Name: ___________________________________ Email address ___________________________

Name on the card: __________________________________ Relationship to Patient: _____________

Type of card: (please circle) Mastercard Visa Discover Amex

Card Number: _____________________________________ Expiration Date: ___________ CVV:_____

Address: ____

□ Please check if this is an updated card and the previous card info should be deleted.

Signature _______________________________ Date _____________________________

Printed Name _________________________________