



REGISTRATION FORM
(PLEASE PRINT OR TYPE)

Today's Date: ____/____/____		Referring Physician:	
Patient's Last Name:		First:	Middle:
Phone #:		Email:	
Birth Date: ____/____/____	Sex: <input type="checkbox"/> Male or <input type="checkbox"/> Female		Age:
Home Address (street):		City:	State: Zip:
Occupation:	Employer:	Employer Address:	Employer Phone #:
How did you hear about us?			
<input type="checkbox"/> Medical Provider <input type="checkbox"/> Family/Friend <input type="checkbox"/> Website <input type="checkbox"/> Insurance <input type="checkbox"/> Google <input type="checkbox"/> Social Media			

INSURANCE INFORMATION

Is this <u>patient</u> covered by insurance? <input type="checkbox"/> YES or <input type="checkbox"/> 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: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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 #:
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IN CASE OF EMERGENCY

Contact Name:	Relationship to Patient:	Primary Phone #:	Secondary Phone #:
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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:
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Email:

<p><u>Please check YES or NO</u></p> <p>Have you or any immediate family member ever been told you have:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%; text-align: center;"><u>Yourself</u></th> <th style="width: 10%; text-align: center;"><u>Family</u></th> <th style="width: 10%;"></th> <th style="width: 10%;"></th> </tr> <tr> <th></th> <th style="text-align: center;"><u>YES</u></th> <th style="text-align: center;"><u>NO</u></th> <th style="text-align: center;"><u>YES</u></th> <th style="text-align: center;"><u>NO</u></th> </tr> </thead> <tbody> <tr><td>Cancer?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Diabetes?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>High blood pressure?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Heart disease?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Chest pain?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Stroke or TIA?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Osteoporosis?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Osteoarthritis?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Rheumatoid arthritis?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td>Head/neck trauma?</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> </tbody> </table> <p>In the past 3 months, have you had, or do you experience:</p> <table style="width: 100%; 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(check ONE)</p> <p><input type="checkbox"/> No difficulty <input type="checkbox"/> Some difficulty <input type="checkbox"/> Extreme difficulty</p> <p>Do you have a problem with: (check ALL that apply)</p> <p><input type="checkbox"/> Hearing <input type="checkbox"/> Vision</p> <p><input type="checkbox"/> Speech <input type="checkbox"/> Communication</p> <p style="text-align: right;"><u>YES</u> <u>NO</u></p> <p>Do you, or have you, smoked tobacco? <input type="checkbox"/> <input type="checkbox"/></p> <p style="padding-left: 20px;">If YES, how many packs/day/week, and for how many years did you smoke? _____</p> <p style="padding-left: 20px;">Last tobacco use? _____</p> <p>Date of last physical exam: _____</p> <p>List ALL medications, vitamins, and supplements you are currently using:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>		<u>YES</u>	<u>NO</u>	Allergies/asthma?	<input type="checkbox"/>	<input type="checkbox"/>	Headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease?	<input type="checkbox"/>	<input type="checkbox"/>	Blood-borne disease?	<input type="checkbox"/>	<input type="checkbox"/>
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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: _____

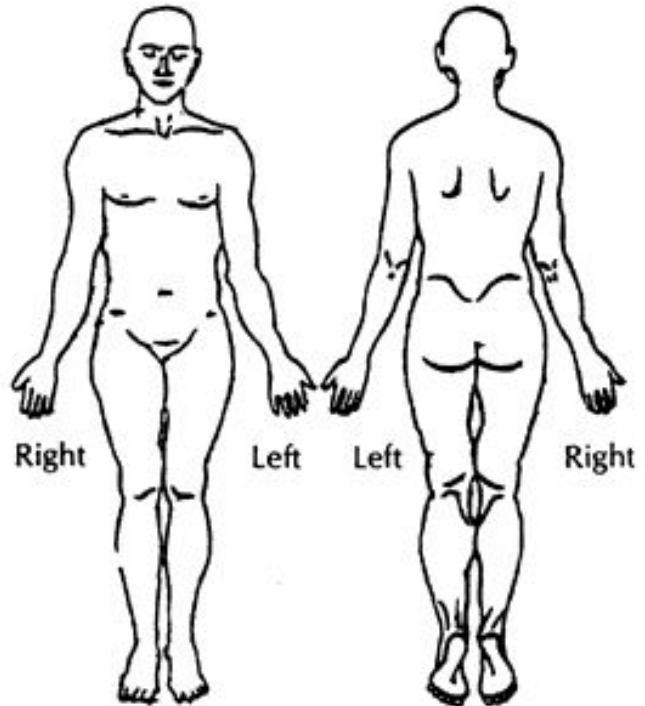
Surgeon's name: _____

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.

Verification and Consent

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 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 be collected at the 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 \$100. If your credit card account is closed or your card has expired, please notify us as soon as possible.

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 call 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.

Signature _____ Date _____

Printed Name _____