

**PATIENT REGISTRATION FORM****Date:** \_\_\_\_\_

Name (First, Middle, Last): \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_ Social Security Number: \_\_\_-\_\_\_-\_\_\_

Phones: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer Name &amp; Address: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Referring Physician Name \_\_\_\_\_ Diagnosis \_\_\_\_\_

With whom may we discuss your account or medical information? \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

**INSURANCE INFORMATION**Primary Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

In-Network Benefits: Co-pay \_\_\_\_\_ Deductible: Y N Deductible Met: \_\_\_\_\_

Out-of-Network Benefits: Co-insurance \_\_\_\_\_ Deductible \_\_\_\_\_

Out-of-pocket max: \_\_\_\_\_ Visits/year \_\_\_\_\_ Visits used \_\_\_\_\_ Visits Authorized \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Relationship \_\_\_\_\_ DOB \_\_\_\_\_

In-Network Benefits: Co-pay \_\_\_\_\_ Deductible: Y N Deductible Met: \_\_\_\_\_

Out-of-Network Benefits: Co-insurance \_\_\_\_\_ Deductible \_\_\_\_\_

Out-of-pocket max: \_\_\_\_\_ Visits/year \_\_\_\_\_ Visits used \_\_\_\_\_ Visits Authorized \_\_\_\_\_

**Motor Vehicle Accident Information**

Date of Accident: \_\_\_\_\_

Nature of Accident: \_\_\_\_\_

Attorney: \_\_\_\_\_

Phone: \_\_\_\_\_

**Worker's Compensation Information**Is this injury related to work? Yes No

Date of injury: \_\_\_/\_\_\_/\_\_\_

WC Contact/Claims Mgr: \_\_\_\_\_

Phone: \_\_\_\_\_

**ORTHOCARE**  
PHYSICAL THERAPY CENTER

**FINANCIAL POLICY**

**I have been notified and understand the following financial policies and responsibilities:**

- I accept full financial responsibility for treatment received at this facility.
- I understand that payment of pre-determined office visit co-pay and co-insurance estimates are due at the time of service.
- I understand that my insurance may only cover a percentage of my total Physical Therapy bill. I agree to pay Orthocare Physical Therapy Center all amounts that are due and owing for services provided which are not otherwise paid for by Medicare, a third party insurance plan, or other payor source, on my behalf for services rendered. In the event that this account is referred to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection including, but not limited to, reasonable attorney’s fees.
- If there is balance remaining at the end of treatment, we will send one courtesy statement to you. I understand payment is due within 30 days from the date I am billed. Account balances are subject to a monthly service charge of 1.5%.
- I understand that I will be charged a fee of \$50.00 if I do not cancel atleast 24 hours prior to my scheduled appointment time.
- I understand that a “No-Show” for scheduled appointment will result in \$50.00 charge to my account.
- I understand that I am responsible for notifying the business office of any address or insurance changes to my account.
- I allow my credit card on file to be charged for any / all expenses accrued throughout my treatment at Orthocare Physical Therapy Center, LLC not limited to copays, co-insurance, deductibles, supplies, and no-show/cancellation fees.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA POLICY**

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights related to protecting my personal health information. I understand that my personal information will be used to:

- Help manage and administer the health care treatment received
- Run the organization
- Obtain payment for rendered health services
- Do research
- Comply with the law
- Address workers’ compensation, law enforcement, and other government requests (if applicable)
- Respond to lawsuits and legal actions (if applicable)

I acknowledge that I received, read, and understand the NOTICE OF PRIVACY PRACTICES which contains a thorough description of the uses and disclosures of my private health information.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**PATIENT ACKNOWLEDGMENT AND AUTHORIZATION OF RELEASE**

The above information is true to the best of my knowledge. I authorize Orthocare Physical Therapy Center, LLC to apply for insurance benefits on my behalf. I understand that I am financially responsible for any balance. I also authorize Orthocare Physical Therapy Center or insurance company to release any information required to process my claims.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT TO TREATMENT**

I consent to receiving outpatient physical therapy services for myself (or my child) and any ancillary services that are deemed medically necessary or appropriate by my physical therapist.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

