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 & 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	Worker's Compensation Information
Date of Accident: _____ Nature of Accident: _____ Attorney: _____ Phone: _____	Is this injury related to work? ___ Yes ____ No Date of injury: ___/____/_____ WC Contact/Claims Mgr:_____ Phone: _____

ORTHOCARE
PHYSICAL THERAPY CENTER

PATIENT REGISTRATION FORM Date: _____

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 ACKOWLEDGMENT 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: _____

ORTHOCARE
PHYSICAL THERAPY CENTER