REGISTRATION FORM

Date:_____

PERSONAL INFORMATION

Name:_____Telephone #'s: (Hm):_____
Name of Parent or Guardian if applicable:_____
Address:_____ (Wk):_____
_____Zip:_____ (Cell):_____
S.S.#_____E-mail Address:_____
Date of Birth:_____Age:_____ Male _____ Female _____
Marital Status (circle one): M S D SEP W If married, Spouse's Name:_____
Are you? Employed _____ Student _____ Employer/School Name:_____
Is your injury a result of an accident? Yes _____ No _____
If yes, date of accident:_____ State of accident:_____

PATIENT BILLING INFORMATION

I understand that the Staff of H/S Therapy has made every effort to obtain accurate insurance benefit information on my behalf but the information provided is not a guarantee of benefits and I agree to not hold them responsible for any inaccuracies. I understand that the best method of obtaining accurate insurance benefit information is to refer to my insurance benefit booklet provided to me by my insurance company or for me to personally contact my insurance company. The information obtained by H/S Therapy is that my benefits for outpatient physical therapy care are:

___ Referral Required ____ Deductible: $_____ ____Co-pay $_____

____Authorization Required ____ Co-Insurance: _____ ____Visit Limitation: _____

Other: _____

I understand that referrals are my responsibility to obtain and that H/S Therapy will submit any necessary paperwork in order to obtain any required authorization. H/S Therapy has no control as to the length of time my insurance company may take to authorize care (if required). I also understand that if my plan has both a deductible and co-pay or co-insurance, my insurance company may assess all or a portion of my charges for physical therapy to my deductible prior to or in addition to assessing a co-pay and/or co-insurance. H/S Therapy has no control as to how my insurance company processes my claims and I agree to address any dispute regarding what I believe to be the incorrect payment of my claims to my insurance company directly. H/S Therapy Associates will assist me in any way possible to solve any claim dispute. I understand that I will be billed for any amount designated by my insurance company to be my responsibility to pay under my plan and that a copy of the explanation of benefits from my insurance carrier will accompany any billing. I agree that I will have 30 days from the date of the bill to make a payment. As long as I continue to make monthly payments towards my account balance, no services charges will be assessed. Should I fail to make monthly payments; a 5% monthly service charge will be assessed. If I have been informed that I have a per visit co-

payment, I agree to pay this co-payment at the time of service rendered. I also agree to personally pay for any supplies (bands, straps, etc.) that I wish to purchase as they will not be billed to my insurance.

CANCELLATION AND NO-SHOW POLICY

In the event of a cancellation, we require a phone call prior to your visit time. When you call, have an alternative time in mind to assure that you are seen the prescribed number of visits that week.

There is a $20 charge for a cancellation without proper notice or for a not showing for a scheduled visit. This charge will not be covered by your insurance company, but will have to be paid by you personally.

PATIENT RELEASES

I hereby authorize H/S Therapy Associates, Inc. to: 1) provide me with physical therapy treatments and 2) to furnish my insurance company(s) with any medical information regarding this injury that may be necessary to process all claims relative to the physical therapy treatments received. I request that payment of authorized insurance benefits for the physical therapy treatments I receive at H/S Therapy Associates, Inc. be made on my behalf directly to H/S Therapy Associates, Inc. I understand that I am legally responsible for any charges for physical therapy services received at H/S Therapy Associates, Inc. which are unpaid by my insurance coverage and deemed by them to be my personal responsibility to pay. I agree to pay H/S Therapy Associates a $25.00 processing charge for any check that I issue that is returned by the bank. Further, if my account is referred for collection, I understand that I will be responsible for any and all collection costs, including court costs and reasonable attorney's fees if applicable.

Signature: _____ Date: _____

HIPPA-PRIVACY NOTICE

By signing this form, I acknowledge that I have reviewed a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and healthcare operations.

Signature:_____Date:_____