Patient Registration

Name: _____ Birth Date: _____ SS#:_____

Address: _____City: _____State:_____ Zip: _____

Marital Status: S M W D Employer: _____Occupation:_____

Home Ph#: _____ Work Ph#: _____ Cell Ph#: _____

Can we e-mail our newsletter to you? _____ e-mail address: _____

Emergency Contact: _____ Relationship to Patient: _____ Ph#:_____

If Patient is a minor, Parent or Guardian's Name: _____

Guardian's Ph#: _____ Guardian's Date of Birth: _____

What are we treating you for today? _____

How did this happen: _____ Date: _____

Who can we thank for referring you? _____Treating Physician: _____

Is this a Work Related Injury or Motor Vehicle Accident? _____ If yes, please complete claim info:

Insurance Company: _____ Date of Injury: _____ Claim Number: _____

Adjuster's Name: _____ Adjuster's Phone: _____

Health Insurance Information:

Primary Insurance Company: _____Ph#: _____

Insurance ID: _____ Group: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Secondary Insurance Company: _____Ph#: _____

Insurance ID: _____ Group: _____

Subscriber's Name: _____Subscriber's DOB: _____

By signing this form, I acknowledge that the information I have provided is accurate and complete. I further acknowledge that I have received or have been offered a copy of the HIPPA Privacy Notice. I authorize insurance payments to be paid directly to Meadows Physical Therapy and Hand Clinic and authorize the release of medical information necessary for TPO (treatment, payment and operations.) I hereby authorize Meadows Physical Therapy to initiate and deliver treatment of therapy services.

_____ _____

Patient/Parent/Guardian Signature **Date**

Financial Agreement

Payment Responsibility I understand as a recipient of medical care I am responsible for all charges regardless of my circumstances for reimbursement. I understand that it is my responsibility to be aware of the requirements and limitations of my own benefits and insurance plans. I understand that a fee is charged for all visits, examinations, treatments and medical reports. Co-pays and/or co-insurance are due at the time of service. I agree to provide Meadows Physical Therapy and Hand Clinic with complete and accurate information, including, but not limited to: picture identification, current insurance card, an authorization or referral for visits or procedures if required. I agree to pay for any service, supply or visit that my therapist deems necessary if not paid by my insurance.

Self-Pay for our patients *not covered by insurance, those who have an insurance policy with no out of network benefits or those whose insurance benefits have been exhausted for the year*; we offer a self-pay plan. Payment is due at the time of service and charges are reduced to $125.00 for the evaluation, $85.00 per visit thereafter and a 20% discount on any supplies provided. If payment is not received at the time of service and we have not made a written payment plan with you, these discounts cannot be offered and the full amount of services rendered will be due. I agree to this policy, if it applies to my circumstances.

HIPAA It is the policy of this practice that all staff preserves the integrity and confidentiality of information relating to our patients by adhering to the standards set forth in the Health Insurance Portability and Accountability Act (HIPAA). My signature below authorizes the release of information to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. My signature below also authorizes the release of information to all parties related to obtaining information from my referring physician for my care and treatment.

Disbursement of Payment I authorize my insurance company to pay and assign all benefits directly to Meadows Physical Therapy and Hand Clinic.

Returned Checks I understand that Meadows Physical Therapy and Hand Clinic charges $25 for any returned check plus the original amount of the check. This must be paid by cash, certified funds or a credit card prior to any additional visits.

Delinquent Accounts I understand if my account becomes delinquent and is turned over to collections, a one-time flat fee of $25.00 is added to my account to cover administrative costs.

Missed Appointment Policy I recognize that everyone's time is important and valuable. The outcome of my treatment depends highly on my keeping scheduled appointments that are reserved for me. My physician and therapist depend on my full participation to achieve therapy goals. I understand that referring physicians are informed of non-compliance and that Meadows reserves the right to charge $25 for missed appointments or cancellations without a 24-hour notice. This fee is my responsibility and must be paid prior to my next visit.

I have read and agree to the above.

_____ _____

Patient/Parent/Guardian Signature **Date**