PATIENT REGISTRATION

CHART # ____________________

Date ______________________

Patient ____ Nickname _________________
FIRST MIDDLE LAST

Address ____
STREET/PO BOX CITY STATE ZIP

Home Phone ______________________ Work Phone _______________________ Cell Phone _________________________

E-mail ____________________________ Social Security # _____________________________ Gender: ☐ M ☐ F

Date of Birth ________________________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Student

Employer ____ Occupation ___________________________________

Employer Address ____

Referring Doctor ____________________________________ Primary Care Doctor ____________________________________

Emergency Contact Name ____ Phone _______________________________

IF YOUR INJURY WAS **JOB RELATED**, FILL OUT THIS SECTION

Employer when injured ____ Date of Injury ____________________________

Employer's Workers Comp. Carrier __________________________________ Claim # __________________________________

Workers Comp. Carrier Address ____

Workers Comp. Carrier Phone _________________________ Claim Status: ☐ Open ☐ Closed ☐ New ☐ Disputed

IF YOUR INJURY WAS FROM A **MOTOR VEHICLE ACCIDENT**, FILL OUT THIS SECTION

Your Auto Insurance Carrier ____ Phone __________________________________

Auto Insurance Carrier Address ____

Name of Insured ______________________________ Date of Injury ________________ Claim # ________________________

Adjuster Name _______________________________________

FOR ALL OTHER **INSURANCE CLAIMS**, FILL OUT THIS SECTION

Primary Insurance Company Name ____ Phone ___________________________

Primary Insurance Company Address ____

Name of Insured ____________________________________ ID# ______________________ Group # ______________________

FOR **SECONDARY INSURANCE** COVERAGE, FILL OUT THIS SECTION

Secondary Insurance Company Name ____ Phone __________________________

Secondary Insurance Company Address ____

Name of Insured _____________________________________ ID# _______________________ Group # _______________________

Payment Agreement

I understand that payment for all therapy services is my responsibility regardless of the insurance or other third party coverage.

We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We will be happy to process your insurance claims and request assignment of private benefits unless you pay in full at the time of treatment. It is your responsibility to understand your insurance policy and coverage. Should insurance benefits paid to us result in a credit balance on your account, your money will be promptly refunded to you or your insurance company.

A monthly statement will be sent to you. We accept payment by cash, check or money order. Past due accounts, over 60 days, will be subject to a monthly rebilling charge. Legal procedures for collection of past due accounts will be initiated if non-payment of account extends beyond 90 days. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts.

For claims in pending litigation (or dispute as to the responsible party), prior written arrangements must be made for consistent payment of the account balance as we are unable to wait for resolution of a dispute. We reserve the right to discontinue treatments if reasonable, regular payments are not made or if the balance becomes untenable.

Medicare – we accept Medicare assignment and we will bill Medicare for you. Medicare pays 80% of the approved amounts and does not allow us to write off any portion of the 20% co-pay or deductible. Please understand that payment in full for all charges is your responsibility.

I authorize payment of medical benefits to Apex Physical Therapy, LLC, and I have read and understand this payment agreement.

Consent to Treat and Authorization to Release Information

I voluntarily consent to *evaluation and treatment* by Apex Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize the *release of information* acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

I authorize *phone messages* regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

A copy of this facility's *Statement of Privacy Notice* has been provided to me.

"No Show" Policy

Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a "no-show." A no-show patient is charged a fee, as set by Apex, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from Apex.

By signing below, I certify that I have read the *Payment Agreement*, *Consent to Treat and Authorization to Release Information*, and *"No Show" Policy* sections above and agree to all statements contained therein.

Patient's Signature ____ Date __________________

Signature of Responsible Party ___________________________________ Relationship ____________________ Date ___________
(if different than patient)