



New Life

...Physical Therapy
...Sports Medicine
...Employee Health

EXPRESS REGISTRATION

(PLEASE PRINT LEGIBLY)

Instructions: Please complete these forms and bring them to your first visit. Thank You!

| A Patient Information | | If Patient is a Minor... | | Parent/Guardian Information | |
|-----------------------|---|--------------------------|---|-----------------------------|---|
| Patient Name | | Parent/Guardian Name | | Parent/Guardian Name | |
| Social Security # | | Social Security # | | Social Security # | |
| Drivers License # | | Drivers License # | | Drivers License # | |
| Birth Date | | Birth Date | | Birth Date | |
| Gender | <input type="checkbox"/> Male <input type="checkbox"/> Female | Relationship | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian | Relationship | <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian |
| Primary Phone | | Primary Phone | | Primary Phone | |
| Other Phone | | Other Phone | | Other Phone | |
| Email Address | | Email Address | | Email Address | |
| Address 1 | | Address 1 | | Address 1 | |
| Address 2 | | Address 2 | | Address 2 | |
| City | | City | | City | |
| State | | State | | State | |
| ZIP | | ZIP | | ZIP | |
| Employer Name | | Employer Name | | Employer Name | |
| Work Phone | | Work Phone | | Work Phone | |

| B Referring Physician Information | |
|-----------------------------------|--|
| Physician Name | |
| Phone | |
| Next Appointment Date | |

| C Insurance Information | |
|--|---|
| PLEASE COMPLETE <u>ALL</u> APPLICABLE BILLING INFORMATION BELOW: | |
| General Health Insurance | |
| <u>Primary Insurance Co.</u> | |
| Member Name | |
| Primary Subscriber | |
| Birth Date | |
| Contract Number | |
| Group Number | |
| Representative's Phone | |
| <u>Secondary Insurance Co.</u> | |
| Member Name | |
| Primary Subscriber | |
| Birth Date | |
| Contract Number | |
| Group Number | |
| Representative's Phone | |
| Other Insurance | |
| Worker Compensation Claim? | <input type="checkbox"/> Yes; <input type="checkbox"/> No |
| Motor Vehicle Accident Claim? | <input type="checkbox"/> Yes; <input type="checkbox"/> No |
| Date of Injury: | _____ |
| <i>If "Yes", please provide the following insurance billing information for Worker Compensation or Motor Vehicle Accident:</i> | |
| Insurance Company | |
| Address 1 | |
| Address 2 | |
| City | |
| State | |
| ZIP | |
| Claim Number | |
| Adjuster's Phone | |
| Case Manager's Phone | |

Note: If your case involves a worker compensation claim, we may be required by law to provide information to your case manager and/or employer. If your case involves a motor vehicle accident claim, we can only bill your auto insurance and may be required by law to provide information to your case manager. Please be aware that you will be responsible for any outstanding balance that may arise from a denial.



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FINANCIAL POLICY

(PLEASE READ CAREFULLY)

Thank you for choosing us as your physical therapy provider. We are privileged to serve you and are committed to providing the best care possible. There are a few things you need to know...

Health Insurance: We participate in numerous insurance plans. For most insurances, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be personally liable for the balance not covered by insurance. **Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company.** We will work with you to determine the extent of your insurance coverage benefits; however we do not guarantee that your insurance company will pay for services rendered. **We recommend that you contact your health insurance provider to verify your coverage.**

Past Due Accounts: 1½% interest will be added monthly to account balances over 30 days. If your account becomes overdue, it may be referred to a collection agency and/or attorney. Legal fees that we pay to secure past due balances will be added to your account. In the event your account is submitted to an outside collection agency, you give your permission to release the necessary information, personal or otherwise, to the outside agency and you acknowledge that you are aware that this information may become a matter of public record.

Returned Checks: A \$35.00 fee will be charged for each check returned to us unpaid by your bank.

Cancellation/No-Show Policy: In order to schedule patients for the care that they need, and for the consideration of other patients, we require a 24 hour cancellation notice if a patient is unable to make a scheduled appointment time. **If a patient fails to show up for an appointment or to cancel 24 hours in advance, a \$25.00 fee may be charged to the patient for each missed appointment.** After the first missed appointment, the patient must contact the clinic **before** the next scheduled appointment, or all future appointments will be canceled to allow for the accommodation of other patients.

Deductibles and Co-Pays: **All patient responsibility deductibles and co-pays are due in full at the time of service.** However as a courtesy to you, if you choose to secure your account with a credit card, we will bill you the exact amount your insurance company states is your responsibility once it processes your claims.

Please check the one option you prefer:

I will pay at time of service. If my health insurance does not cover my visits 100%, I will pay an estimated amount of my patient financial responsibility with each visit, based upon verification of my health insurance company's explanation of benefits. I understand that this is just an estimated amount and the actual amount due may be more or less than what is collected. Any overpayment will be refunded upon final processing of all claims.

Please bill me. I understand my credit card will be automatically charged for any balance due that is not paid by the due date on my statement. I also understand that if my credit card is due to expire while in treatment, and new credit card information is not supplied before the expiration date, an estimated amount will be applied to my credit card for all past appointments. **Please provide your credit card to the front-desk personnel. Debit cards cannot be used to secure an account. Please DO NOT fill in the following information, but bring your credit card to the front desk:**

| |
|--|
| CREDIT CARD: <input type="checkbox"/> VISA, <input type="checkbox"/> MASTERCARD, <input type="checkbox"/> OTHER: _____ |
| NAME ON CARD: _____ |
| ACCT #: _____ |
| EXPIRATION: ____/____/____ |
| SECURITY CODE: _____, ZIP CODE: _____ |
| <i>(FOR OFFICE USE ONLY – PRINT LEGIBLY)</i> |

I would like to discuss a payment plan.

I have read This Financial Policy and I agree to the terms and conditions outlined within this policy. I hereby consent to medical care and treatment as deemed necessary and proper by my Physical Therapist. Furthermore, I agree to assign all health insurance benefits directly to the above named provider and understand that I am responsible for any costs not covered by my health insurance.

(Note: If the patient is a minor (under age 18), a parent or legal guardian must sign this agreement.)

X _____
Signature of patient, parent or legal guardian *Date*

Would you like a copy of our HIPAA Privacy Notice?
(Please check and initial your preference below...)

No / Refused **X** _____; Yes / Received **X** _____

| | | | |
|---------------------------|---|--|--|
| Insurance Estimate | Insurance Company | | The adjacent table is only a benefit quote given by your insurance company and is an estimate based on that quote. It is not a guarantee of payment by your health insurance company. You may be billed in addition to the quoted amounts based on how your insurance company applies your deductible and co-insurance. You also may be billed for services that your insurance company does not cover. Your co-pays are to be paid at the time of each visit. Deductibles and co-insurance are to be paid at time of visit unless your account is secured by credit card. We strongly suggest that you call your insurance company and verify that this quote is correct as we are at times misquoted. It is also important that you understand what your health insurance company does and does not cover. You are responsible for knowing your insurance benefits and restrictions. |
| Verified By: | At Phone Number | | |
| | Representative's Name | | |
| | Deductible | | |
| | Co-insurance | | |
| | Co-pay per visit | | |
| | Estimated cost/visit <u>until</u> deductible is met | | |
| | Estimated cost/visit <u>after</u> deductible is met | | |