FAMILY PHYSICAL THERAPY SERVICES, INC.

207 Meetinghouse Road, Bedford, NH 03110

CONFIDENTIAL PATIENT REGISTRATION FORM

Please mark the reason you chose Family Physical Therapy for your current condition:

☐ Physician Referral ☐ Insurance Plan ☐ Family Member ☐ Friend ☐ Previous Patient
☐ Internet ☐ Advertisement ☐ Telephone Book ☐ Close to Home ☐ Close to Work
☐ Newsletter ☐ Special Program _____ ☐ Other _____

PATIENT INFORMATION

Name: last: _____ first: _____ middle initial:_____

HomeAddress:_____City: _____State: _____Zip: _____

Mailing Address: _____City: _____ State: _____Zip: _____

Social Security #: _____ Birth Date: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female

Are You Employed?: ☐ yes ☐ no Work hours _____ Are you disabled? ☐ yes ☐ no

Occupation: _____Employer: _____

Employers Address: _____City: _____State: _____Zip: _____

Are you a Student?: ☐ yes ☐ no ☐ Full time ☐ Part time

CONTACT INFORMATION

Telephone: Home: _____ Cell: _____ Work: _____

Email Address: _____

In case of emergency please contact:

Name: _____ Relationship to patient: _____

Telephone: Home: _____ Cell: _____ Work: _____

Primary Care Physician's Name: _____ Telephone: _____

Referring Physician's Name: _____ Telephone: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize FPTS (Family Physical Therapy Services, Inc.) to release information during the course of my treatment including but not limited to medical records, verbal, and written communications to my physicians, insurance company, employer, and third party payers via fax, phone, paper, or electronically.

Patient Signature: _____ Date: _____
(Parent or Guardian if Minor)

I authorize FPTS to release information during the course of my treatment including but not limited to medical records, verbal, and written communications to my ☐ spouse ☐ mother ☐ father ☐ other _____ via fax, phone, paper, or electronically.

Patient Signature: _____ Date: _____
(Parent or Guardian if Minor)

CONFIDENTIAL INSURANCE INFORMATION

HEALTH INSURANCE

Insurance Name**:** _____Telephone: _____

Mailing Address: _____City: _____ State: _____Zip: _____

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other

Insured's SS#: _____ ID#: _____ Group #: _____

Effective Date: _____ Authorization req. ☐ yes ☐ no Co-pay $____ Co-ins. $____Remaining Deductible $____

FINANCIAL RESPONSIBILITY / GUARANTOR INFORMATION:

Name: _____ Relationship to Patient: _____

Home/Mailing Address:_____City: _____State: _____Zip: _____

Social Security #: _____ Birth Date: ____/____/____ Employer: _____

Employers Address: _____City: _____State: ____ Zip: _____

Telephone: Home: _____ Cell: _____ Work: _____

Has the person listed here filed bankruptcy during the past 5 years?: ☐ yes ☐ no

Does the person listed here currently have any liens against assets?: ☐ yes ☐ no

AUTOMOBILE INSURANCE

Is this injury related to a motor vehicle accident?: ☐ yes ☐ no **If yes, please fill out below:**

Date of Injury: ____/____/_____ Name of Insured: _____

Auto Insurance Company: _____

Mailing Address: _____City: _____ State: _____Zip: _____

Telephone: _____ Policy #: _____Claim #: _____

WORKER'S COMPENSATION

Is this injury related to a workers compensation claim?: ☐ yes ☐ no **If yes, please fill out below:**

Date of Injury: ____/____/_____ Claim Number: _____

Insurance Carrier Name: _____

Mailing Address: _____City: _____ State: _____Zip: _____

Name of Adjuster: _____ Telephone: Voice: _____ Fax: _____

Employer at the time of the injury: _____Telephone: _____

Mailing Address: _____City: _____ State: _____Zip: _____

ATTORNEY INFORMATION

Is there an attorney involved?: ☐ yes ☐ no **If yes, please fill out below:**

Attorney's Name: _____ Telephone: Voice: _____ Fax: _____

Mailing Address: _____City: _____ State: _____Zip: _____

Family Physical Therapy Services, Inc.

MEDICAL HISTORY

Reason for visit: _____

Date of: ☐ Injury ☐ Accident ☐ Illness: _____ Cause: ☐ Auto ☐ Work ☐ Other

	Yes	No	Comments		Yes	No	Comments
Stroke	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Lung Disease	☐	☐	_____
Low blood sugar	☐	☐	_____	Diabetes	☐	☐	_____
Seizure Disorder	☐	☐	_____	Cancer	☐	☐	_____
Joint Replacement	☐	☐	_____	Arthritis	☐	☐	_____
Pins/metal implants	☐	☐	_____	Osteoporosis	☐	☐	_____
Loss of balance	☐	☐	_____	Pacemaker	☐	☐	_____
Difficulty walking	☐	☐	_____	jt pain/swelling	☐	☐	_____
Sensitivity to heat/cold	☐	☐	_____	do you smoke	☐	☐	_____
Hearing impairments	☐	☐	_____	fibromyalgia	☐	☐	_____
Visual impairments	☐	☐	_____	Are you pregnant	☐	☐	_____

other: _____

ORTHOPEDIC HISTORY

Have you ever had surgery, sprained, strained, dislocated, fractured or injured your:

☐ head/neck ☐ spine ☐ arms ☐ legs ☐ pelvis ☐ other (please give dates and treatment received if any):

_____

_____

_____

_____

Medications presently taking (please list):_____

_____

_____

MEDICAL OR REHABILITATIVE SERVICES

Have you had any of the following medical or rehabilitative services for **this** injury ☐ (Please check all that apply)

☐ Primary Care Physician	☐ Physical Therapy	☐ Podiatrist	☐ Massage Therapist
☐ Orthopedist	☐ Occupational Therapy	☐ Chiropractic	☐ Neurologist
☐ Rheumatologist	☐ Other: _____		

CLINICAL TESTS

Have you had any of the following tests for **this** injury or prior injuries within the past year□ (Check all that apply)

☐ Angiogram	☐ Bronchoscopy	☐ Mammogram	☐ Spinal Tap
☐ Arthroscopy	☐ CT Scan	☐ MRI	☐ Stress test
☐ Biopsy	☐ EEG (electroencephalogram)	☐ Myelogram	☐ Ultrasound
☐ Blood Tests	☐ EKG (electrocardiogram)	☐ Nerve Conduction Velocity	☐ X-ray
☐ Bone Scan	☐ EMG (electromyogram)	☐ Pulmonary Function test	☐ Other _____

I certify that the above information is correct to the best of my knowledge. I will not hold my therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. **Please notify us of any changes in medical condition immediately.**

Patient Name (printed): _____ Patient Signature: _____ Date: _____

Family Physical Therapy Services, Inc.

FINANCIAL AGREEMENT

Please read each section and initial to the left

Thank you for choosing Family Physical Therapy Services. We are committed to your treatment being successful from start to finish. **As such, we verify your benefits with your insurer, but delays in processing prior treatment may impact the information that we receive, and ultimately your benefits at FPTS.** *Please understand that payment of your bill in full, including co-pays, deductibles, co-payments or denials, is considered a part of your treatment.* The following is a statement of our Financial Agreement which we require you to read and sign prior to any treatment.

☐ FULL PAYMENT IS DUE ON PATIENT BALANCE ON A WEEKLY BASIS. We request your portion of the bill be paid on a weekly basis. Statements will be provided to you. The charges accrued for services rendered are subject to interest of 1 1/2% per month, (18% per annum) compounded or a minimum of $10.00 per month if payment has not been received within 30 days.

☐ Methods of Payment: Cash, Check, Credit Card (Visa, MC), and Patient Financing options for those who are credit worthy.

☐ We do our best to obtain accurate information from your insurance company regarding physical therapy benefits. Unfortunately with the many changes with the insurance industry and the private nature of your policy, we can not be expected to know the details of each and every agreement. IT IS YOUR RESPONSIBILITY TO OBTAIN AND VERIFY YOUR BENEFITS & AUTHORIZATIONS FROM YOUR INSURANCE CARRIER AND YOUR PRIMARY CARE PHYSICIAN (PCP). Additionally, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. You are responsible for contacting your insurance company to obtain as much information on your physical therapy coverage and share your findings with the financial office.

☐ All claims will be submitted directly to your PRIMARY insurance company on a weekly basis if proper paperwork is provided to us. Although we are billing your insurance company for you, we want you to understand that the BALANCE IN FULL is your responsibility. WE ARE NOT RESPONSIBLE FOR DEDUCTIBLES, CO-INSURANCE, OR CO-PAYMENTS. **You agree to assume full financial responsibility on all charges in excess of or denied by insurance, compensation or Medicare plans**. Please note: we do not bill secondary insurance companies except for Medicare recipients.

☐ You are responsible for notification of changes in your insurance coverage. Failure to do so that results in denial of your claims will result in your being responsible for your bill in its entirety with the balance due and payable in full.

☐ For returned checks we assess a $25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

☐ If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections patient agrees to pay all additional fees accessed in the collection of the debt. These fees include collection agency fees and attorney fees.

☐ If you are pursuing legal action for the injuries/conditions for which we are treating you, this agreement provides a **Letter Of Protection** ensuring that any proceeds recovered from the disposition of that legal action will be applied against any outstanding balance owed to Family Physical Therapy Service, Inc.

☐ CANCELLED APPOINTMENTS, NO-SHOWS AND LATE ARRIVALS: Unless canceled at least 24 hours in advance, our policy is to charge $75 for missed appointments. Late arrivals for scheduled appointment times will also incur a $30 fee. These fees are not billable to your insurance.

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AUTHORIZATION IS GRANTED FOR PAYMENT DIRECTLY TO FAMILY PHYSICAL THERAPY SERVICES, INC, OF ALL GROUP OR INDIVIDUAL INSURANCE BENEFITS PAYABLE AS A RESULT OF TREATMENT. AUTHORIZATION IS ALSO GRANTED TO FPTS TO RELEASE INFORMATION PERTAINING TO MY TREATMENT TO THE PAYER OR ITS REPRESENTATIVES VIA FAX, PHONE, PAPER, OR ELECTRONICALLY.

The patient is ultimately responsible for all fees for services. I have read, understand, and agree to the above financial policy for payments of professional fees. I hereby consent to the necessary credit investigation in connection with this application. I warrant that all information contained in this application is true and complete.

X _____ _____

Signature of Patient or Responsible Party — Date

WORKERS COMPENSATION

If Workers Compensation denies my claim in part or in full, I understand that I am personally responsible for the payment of the total balance due. In the case that I appeal a denied claim, I understand that my account will accrue service charges at the rate of 1 1/2% or a minimum of $10.00 a month, to which I will be personally responsible no matter the outcome of the appeal.

X _____ _____

Signature of Patient or Responsible Party — Date

Family Physical Therapy Services, Inc.

207 Meetinghouse Rd, Bedford, NH 03110 ~ 603-644-8334

PRIVACY PROCEDURES

In response to HIPAA (Health Insurance Portability and Accountability Act of 1996) we are required to develop internal procedures to assure that patient privacy is secured and that we are able to guarantee patients rights and protections against the misuse or disclosure of their health records. Such information includes all medical records or health information which is used or disclosed by Family Physical Therapy Services, Inc. (FPTS), as a health care provider who conducts certain financial and administrative transactions or activities (i.e. electronic billing, maintenance of treatment records, correspondence with ancillary medical offices, MD offices, hospitals, insurance companies and their representatives) whether electronically, on paper, or verbally.

We are required to:

- Give patients clear written explanation of how FPTS will use and disclose their health information. (Exhibit A)
- Provide copies of patient's records upon their request and upon their completion of the "Attestation of receipt of Medical Records" (Exhibit B)
- Allow patients to request amendments to their records. (Exhibit C)
- Allow patients access to a history of non-routine disclosures. (Exhibit D)
- Obtain patient consent prior to obtaining or releasing information for treatment, payment, and health care purposes. (Exhibit E, F, I, J)
- Allow patients to request restrictions on uses and disclosure of patient information. (Exhibit G)
- Allow patients the right to file a formal complaint with FPTS or HHS (Health and Human Services), about violations of HIPAA or the policies and procedures of FPTS concerning compliance with HIPAA. (Exhibit H)
- Assure that patient records are used only for health purposes and may not be used for purposes not related to health care such as employers, financial institutions, or marketing without explicit authorization from the individual.

Employees will be required to read and understand FPTS Privacy Procedures, and will be familiar with Exhibits A through J. Appropriate authorizations, signatures, and documentation must be completed prior to release or acquisition of any medical records on behalf of the patient. Cathy J. Leer, is hereby designated as the individual responsible for ensuring that these procedures are complied with. If questions arise pertaining to any of the above mentioned procedures, Cathy J. Leer should be consulted.

In certain circumstances, the final HIPAA rule permits but does not require, FPTS to disclose health information without individual authorization for specific public responsibilities including: emergency circumstances; identification of the body of a deceased person or the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

I: _____ /_____,
Patient name Signature

hereby acknowledges receipt of this document and information. Date: _____

Patient Insurance and Financial Responsibilities

Thank you for choosing FPTS for your physical therapy.

Before we can provide care to you, we need to obtain accurate information regarding your insurance coverage and financial situation to offer the best choices available to you. This can be a difficult process for us since there are so many different insurance companies and policies, often with limited information available to us.

Because insurance coverage is an agreement between you and your insurer, it is ultimately your responsibility as our patient to know how the costs of your treatment will be paid, whether to us or any other provider. This document highlights insurance information you should be aware of and share with us as your provider.

Your Cost Share

Be aware of how your insurer and you share the costs of your treatment. For example, you may be responsible for paying co-pays, deductibles, and/or other co-insurance. Keeping us informed will help to minimize your financial burden.

Required Authorizations

Often insurance policies require authorizations for treatment prior to you being treated. You are responsible for checking with your insurance carrier and providing this information to us. For example, your insurance may deny coverage because you did not get a physician referral or other related authorizations prior to treatment. Unfortunately, if you do not tell us prior to treatment, it will be your responsibility for the balance due.

Policy Changes

Insurers change policy coverage from from year to year. Whether you are a new or returning patient, we look to you to provide us with the latest information about your insurance coverage.

Our Assistance

We provide a team approach to your care. As our patient, you are the key member of that team for identifying the insurance and financial information to minimize insurance denials and unwanted out-of-pocket costs.

Patient Name _____ Date _____
(Please Print)

Patient signature _____

Cathy J Leer, PT, MBA – Owner/Director
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