

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: _____

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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pins/metal implants	<input type="checkbox"/>	<input type="checkbox"/>	_____	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
Difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	_____	jt pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sensitivity to heat/cold	<input type="checkbox"/>	<input type="checkbox"/>	_____	do you smoke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing impairments	<input type="checkbox"/>	<input type="checkbox"/>	_____	fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visual impairments	<input type="checkbox"/>	<input type="checkbox"/>	_____	Are you pregnant	<input type="checkbox"/>	<input type="checkbox"/>	_____
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. Please understand that payment of your bill 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 AUTHORIZATIONS FROM 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. We recommend that you also contact your insurance company and 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 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.

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: _____