Patient Registration

Please fill out ALL fields, completely & legibly

Todays Date_____/_____/_____

Patient Information

Last Name_____ First Name_____ MI_____

Address _____ City_____ State_____ ZIP_____

Home phone_____ Mobile_____ Email_____

Social Security #_____ Date of Birth_____/_____/_____ Male/Female Single / Married

Emergency Contact_____ Relationship_____ Phone_____

Work Status: ____Employed ____Unemployed ____Retired ____Disabled (Permanent or Temporary)

Do you give permission for any others to access your personal health information (PHI)? __No __Yes*
*Name(s)_____

Your Condition

I am here seeking services because of…..(brief description)

___**General / No specific event**_____

___**Injury / surgery**_____

Date____/____/_____ Surgeon_____

___**Work Injury**_____ Date____/____/_____

*Employer*_____*Phone #*_____

*Address*_____

*City*_____ *State*_____ *ZIP* _____

___**Auto/ Personal Injury** **(***Additional forms must be completed)*

HOME HEALTH ***IMPORTANT!*** *You MUST be discharged from home health before beginning treatment with us. Are you currently receiving **home health** care? __No __Yes
If yes, who is your Home Health provider?

_____ If you have recently been discharged, what was your discharge date:_____

How did you find us?

Try to be as specific as possible

___**Previous patient** When:_____

___**Referred to us OR Word of mouth** by:

___ MD / Medical practitioner

Name_____

Office_____

___Friend / neighbor / co-worker./_____

May we contact & thank them? __No __Yes

If Yes, Name_____

Phone / Email_____

___**Internet**_____

___**Ad/Signage**_____

___**Other**_____

Payment

How will you pay for your treatment? *(please check only one)*

___ Insurance: ___Worker's Comp ___Motor Vehicle___ Self pay (must be paid in full at time of service):

If Insurance, choose all that apply: __Medicare (primary OR secondary) ____Personal Insurance.
Who is the primary insured? ___*Self* ___*Someone else*

*If someone else, Name*_____ *DOB*____/____/_____*Relationship:* _____

__ Requesting payment plan (ask front desk for details) __Apply for financial hardship (complete additional forms)

Name of person filling out form:_____ Initial each page_____

Important Policies for a Successful Relationship

Please review carefully and feel free to ask questions.

CANCELLATION POLICY

- _____*(Initial)* As all services are provided by appointment only, we ask you for a minimum of 48 hours' notice for initial evaluation and 24 hours' notice for regular visit cancellations. Cancellations must be made either by telephone or in person - replies to our automated text message and email reminders do not reach us.

- _____*(Initial)* A $30 fee will be imposed for each missed appointment for which we do not receive notification (No-Show). Payment is expected prior to continuing therapy. Therapy will be discontinued after 2 No-Shows.

- _____*(Initial)* After 1 same day cancellation (within 24 hrs of your scheduled visit), any subsequent same day cancellations will also carry a $30 fee. Therapy may be discontinued after 2 same day cancellations at your therapist's discretion.

The No-Show fee of $30 can be avoided by calling to cancel 48 hours in advance for initial evaluations and 24 hrs. in advance for regular visits, OR by rescheduling the missed visit within the same business week. Lack of available appointments to reschedule does not absolve you from financial responsibility for this fee.

We understand that emergency situations arise. Please communicate this when you call and they will be handled on an individual basis.

If you are calling after hours, you may leave a message on our voicemail system to cancel or reschedule your appointment. If you will be late for your appointment, please call us so that we may advise you if you can be accommodated, or if we will need to reschedule your appointment.

*Please understand **empty appointments are costly to our company,** so thank you for working with us to keep our costs down so that we can serve everyone.*

LATE POLICY: Please call us ASAP if / when you know you are going to be late. If you are more than 10 minutes late for your appointment, we, and your therapist, reserve the right to consider it a no-show and will follow the above policy guidelines.

PAYMENT AT TIME OF SERVICE: Unless you fill out a Financial Hardship form AND qualify for financial assistance under state or federal guidelines, it is unlawful for us to waive or discount your fees, including co-pays, co-insurance, or deductible payments. *If you are unable to pay your coinsurance / deductible, please ask our front desk staff for the Financial Hardship application forms.*

PAYMENT PLAN: You may qualify for a payment plan if: (1).You pay 50% of your fees due at the time of service; and (2). You agree to, and sign, our Payment Plan forms outlining your responsibilities. *Please ask our front desk staff for more details and the forms.*

CELL PHONE POLICY: Please, out of courtesy to your therapist and other patients in our facility, turn off or silence your phone / device while in our office. If you have an emergency or urgent need to be reached, it is fine to keep it with you during your treatment, just let our staff, including your therapist, know that.

***CHILD WATCH POLICY*:** We offer a child watch in our play room for children of patients & gym clients that do NOT need direct 1-on-1 supervision. Your child may come into your treatment with you IF he/she is capable of sitting quietly in the room without disturbing the treatment session. If the child becomes disruptive your therapist may request they be moved to the play room or end the session.

Name of person filling out form:_____ Initial each page_____

Treatment Plan of Care (POC) and Goal Setting

Using the information gathered during the initial evaluation, along with the most current medical and physical therapy evidence, your therapist will propose a treatment plan of care, which includes: a description of the treatment to be provided, an explanation of the risks which may be associated with the therapy, expected benefits from the proposed treatment, anticipated timeframes and costs, and reasonable alternatives. Then specific therapy goals will be established to help you overcome your limitations and achieve recovery as quickly and safely as possible.

Your POC will be tailored to meet your individual goals, taking into consideration your condition, medical history, and experience with movement & exercise. It is not possible to predict the exact results or outcomes of treatment(s), nor the exact timeframes, as each person reacts and responds differently. But rest assured our clinical staff are trained in the most current evidence-based treatments and have a large wealth of knowledge and experience from which to draw their choice of treatment(s).

Consent to Treatment

This section gives us your legal permission to carry out evaluation and treatment, including accessing your medical records and personal health information. Please read and initial below.

_____ (Initial) **I hereby direct and allow Physical Therapy of Leicester, Inc. (PTOL, d/b/a Asheville Family Fitness & Physical Therapy) and its employees to provide Physical Therapy services, including examinations and treatment procedures, as deemed necessary and appropriate by the licensed PT. I understand that while this consent is voluntary, if I refuse to sign this PTOL can refuse to provide services. I also understand that I may revoke this consent at any time by notifying PTOL, in writing, but that if I revoke my consent such revocation will not affect any actions that PTOL took before receiving my revocation.**

_____ **(Initial)** **I understand this is a teaching facility and I allow credentialed students, as supervised by the licensed Physical Therapist, to participate in my care, including access to my personal health information as it relates to my Physical Therapy treatment and plan of care. I understand I have a right to refuse this authorization and that PTOL will honor that.**

_____ **(Initial)** **I have read and understand PTOL's *Important Policies* form, including the cancellation policy, and agree to the guidelines contained therein.**

_____ **(Initial)** **I have read and fully understand PTOL's *Notice of Privacy and Patient Information Practices* and I consent to such policies related to PTOL's use and disclosure of my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any other administrative operations related to treatment or obtaining payment. I understand that I have the right to request, in writing, the restriction of how my personal health information is used and disclosed for these purposes. I am aware, however, that the practice does not necessarily have to agree to such requests.**

Patient (or Guardian) Signature: _____ **Date:** _____

Relationship to patient (if not self)_____

Assignment of My Insurance Benefits

IF USING HEALTH INSURANCE TO PAY YOUR BILLS, YOU MUST READ & INITIAL BELOW
This section gives us legal permission to deal directly with your insurance company on your behalf.

_____ **(Initial)** **I agree and request that payment of authorized insurance benefits made on my behalf be assigned to PTOL for application to my account in payment of services rendered. PTOL will, AS A COURTESY, attempt to make reasonable and necessary efforts to obtain payment from my insurance company for services provided. But I acknowledge it is my responsibility to check with my insurance carrier to verify my benefits and coverages including in/out of network status, deductibles, co-pays, and co-insurances, and I accept responsibility for any allowable fees that exceed payment made by my insurance OR if PTOL does not participate with my insurance.**

_____ **(Initial)** **I acknowledge that I am ultimately responsible for discerning my financial responsibility according to any insurance policy as well as for any and all balances left unpaid on my account, whether by copay, coinsurance, deductible or non-payment by insurance. If deemed necessary, a payment plan may be set forth by PTOL for reimbursement of charges incurred for services rendered. Payment in full of all balances owed may be demanded at any time and are payable by the date set forth by PTOL. Any late or non-payment of charges may result in late and/or interest fees being added to my account balance, as well as my account being sent to a collection agency if payment is not made according to terms set forth by PTOL. A collections fee will be added to my account balance in the event a collection agency becomes involved in recouping charges owed.**

_____ **(Initial)** ***If covered by Medicare*, I hereby authorize the release and disclosure of my personal health information to information to the Social Security Administration and/or its intermediaries or carriers as it pertains to this or a related Medicare claim.**

_____ **(Initial)** **I give my consent for PTOL staff to leave detailed messages concerning my physical therapy visits at the home and mobile telephone numbers provided by me.**

Patient (or Guardian) Signature: _____ **Date:** _____

Relationship to patient (if not self)_____