

Today's Date: _____

PATIENT REGISTRATION FORM

Patient Information

Patient Name: _____ DOB: _____

Mailing Address: _____ SS#: _____

City: _____ ST: _____ ZIP: _____

PH: _____ CELL: _____ WORK: _____

Gender: M F Status: S M O If Married, Spouses Name: _____

Under 18: Y N If Yes, Parent/Gaurdian Name & DOB: _____

Email: _____

Location: Portsmouth PT (10) Brentwood PT (20) Portsmouth Program (15) Brentwood Program (25)

Medical Information

Referred By: _____ Practice Name/Phone: _____

Primary Care Physician: _____ Practice Name/Phone: _____

Diagnosis: _____ Date returning to the Doctor: _____

Have you been seen by a chiropractor or physical therapist for this condition? Y N

If yes, how many visits and name of the provider: _____

Have you received out patient or home care within the last 60 days? Y N

If yes, how many visits and name of the provider: _____

Work/Co/Auto

Work Comp: Y N Auto Accident: Y N If Yes to Auto or Work Comp, please complete below

Employer: _____ Date of Injury: _____

Address: _____ Adjuster: _____

City: _____ ST: _____ ZIP: _____ Claim/Case#: _____

Primary Insurance

Insurance 1: _____ ID: _____ Group #: _____

Insurance Address: _____

Subscriber Dependent If Dependent, Subscriber Name: _____ DOB: _____

Effective Date: _____ Referral Required: Y N Pre Certification Required: Y N

Co Pay: _____ Coinsurance: _____ Deductible: _____ Met Deductible: Y N

Visit Max: _____ Per Cal Yr Per Member Yr \$ Max: _____ Per Cal Yr Per Member Yr

Verified By: _____ Date Verified: _____

Secondary Insurance

Insurance 2: _____ ID: _____ Group #: _____

Insurance Address: _____

Subscriber Dependent If Dependent, Subscriber Name: _____ DOB: _____

Effective Date: _____ Referral Required: Y N Pre Certification Required: Y N

Co Pay: _____ Coinsurance: _____ Deductible: _____ Met Deductible: Y N

Visit Max: _____ Per Cal Yr Per Member Yr \$ Max: _____ Per Cal Yr Per Member Yr

Verified By: _____ Date Verified: _____

Appointments

1st Appt Date: _____ 2nd Appt. Date: _____

Date: _____ Date: _____

Time: _____ Time: _____

Therapist: _____ Therapist: _____

Scheduled By: _____



Please initial on the line to the left of each section to show you understand and agree to the information provided.

 CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Abilities Rehabilitation Center** to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical and mental condition.

 BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to **Abilities Rehabilitation Center**. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

 PRIVACY PRACTICE

I, the undersigned, have read the privacy practice and give my consent to your use and disclosure of my health information.

 FINANCIAL POLICY STATEMENT

It is your responsibility to know your insurance policy and initiate a referral when necessary. We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal **usual and customary fee schedule**, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit it to **Abilities Rehabilitation Center**. The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim w/c benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check you expressly authorize Abilities Rehabilitation Center, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not; however mean that **Abilities Rehabilitation Center** cannot collect a returned check fee by other methods. We charge a \$25.00 fee for any returned check. If a check is returned you will not be permitted to use this form of payment in the future. **We charge a \$25.00 fee for any cancellation not done within 24 hours and failing to show up for an appointment.** I understand and agree that if I fail to make any of the payments for which I am responsible; I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

 ESTIMATED RESPONSIBILITY: Co Pay: _____ Coinsurance: _____ Deductible: _____

I understand this amount is only an estimate and listed as a courtesy. I am responsible for knowing my benefits.

I understand this amount is due each visit.

I have read and understand the above information. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient Signature or Guardian/Responsible party

Date

Center Representative Signature/Witness

Date

CONFIDENTIALITY AGREEMENT:

We are unable to share information with any person other than the patient. Please list all those you give permission for us to discuss your medical condition, appointments, and billing information with. Please list your relationship to the person and a contact number for them.

Name: _____ Relationship: _____ PH: _____

Name: _____ Relationship: _____ PH: _____

Name: _____ Relationship: _____ PH: _____