

PATIENT REGISTRATION

Patient # (for office use only) _____

Date: ____ / ____ / ____

Patient: _____
Last Name First Name Initial

Mailing Address: _____
City: _____ State: _____ Zip: _____

Home Phone: (____) _____ **Work:** (____) _____ **Cell:** (____) _____

Gender: M F **S S#:** _____ - _____ - _____ **Date of Birth:** ____ / ____ / ____

Marital Status: Single Married Other **Employed** No Yes **Full-Time Student** No Yes

Patient's Employer: _____ *Address:* _____
Occupation: _____

Emergency Contact: _____ *Relationship to Patient:* _____ *Phone:* (____) _____

BILLING INFORMATION

Do you have Medical Insurance? No Yes *Responsible Party (if a minor):* _____

Name of Primary Health Insurance: _____
Who is the insured member? _____ *Relationship to Patient:* _____

Name of Secondary Health Insurance (if any): _____
Who is the insured member? _____ *Relationship to Patient:* _____

Please present your card(s) to the receptionist for photocopying.

Self-Pay Patient Payment Arrangement: Cash/Check MC/Visa, Amex, Discover (please circle)
Credit Card # (including V code): _____

HIPAA PRIVACY INFORMATION- DO NOT LEAVE BLANK

Indicate if there are **any family members or close friends ONLY(not doctors)** with whom we may discuss your health care.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

How did you learn of our practice? _____

Referring doctor: _____

ATTENTION!

IF YOUR INJURY/ILLNESS IS DUE TO ANY WORKERS' COMPENSATION, MOTOR VEHICLE ACCIDENT, OR OTHER TYPE OF LITIGATION CASE, YOU MUST DISCLOSE THIS TO THE OFFICE STAFF UPON CHECK-IN YOUR FIRST VISIT AT TRU-CARE PHYSICAL THERAPY.

FAILURE TO COMPLY WITH ABOVE STATEMENT CONSTITUTES ACKNOWLEDGEMENT THAT A \$50.00 BILL REPROCESSING FEE WILL BE CHARGED WHERE APPLICABLE

Billing, Payments and Privacy

1. If I have health insurance coverage, automobile medical payment coverage, other liability coverage or lien arrangements that will pay for a portion of the physical therapy services, Tru-Care Physical Therapy will bill the insurance company, provided the patient provides the billing department with all necessary information to process the billing. I understand that this office will only attempt one rebilling.
2. The patient will be responsible for immediate payment of those fees which the private insurance company or other third party payer does not pay. Payment in full of these unreimbursed or additional fees (this includes any deductible, co-insurance or denied services applied by the insurance carrier), is expected at the time the services are rendered. It is understood that any payment received from a third party will be credited to my account and I will be personally responsible for the balance after a 30-day period. Our policy is to send invoices monthly on any account with patient portions due. This invoice summarizes the charges incurred, any payments the patient has made, any payments received from insurance companies or other third party payers, and the outstanding balance due.
3. As indicated above payment is expected at the time the services are rendered. It is further understood that if I do not pay any amount which is owed to Tru-Care Physical Therapy, Inc. within 30 days after receipt of statement for services rendered, I will be in default of this agreement and will pay any and all reasonable attorney, legal and collection fees accrued in attempts to collect payment. Additionally, a service charge of 1 1/2% /month, 18% APR will be added to all overdue accounts. It should be noted that acceptance of late or partial payment does not constitute a waiver of a breach of the agreement.
4. If there is a problem with collection of payment from the third party for any reason, I understand that I am ultimately responsible for payment of services.
5. I here by agree to these terms and authorize evaluation and treatment by Tru-Care Physical Therapy, Inc.

Patient: I have been offered and received / declined the Notice of Privacy Practices from Tru-Care Physical Therapy, Inc.

Tru-Care Physical Therapy Representative: As a staff member of Tru-Care Physical Therapy, I state that the patient named below has been offered and received / declined the Notice of Privacy Practices from Tru-Care Physical Therapy, Inc.

Name of patient

Date

Signature of patient

Signature of patient representative

Tru-Care Physical Therapy
Representative