ADVANCED REHAB, PC

Patient Registration Form

PATIENT INFORMATION **Today's Date:**_____

First Name:_____MI_____Last Name:_____

Mail Address:_____

City:_____ State:_____Zip:_____Email:_____

Home Phone:_____Work:_____Cell:_____

Employer:_____Occupation:_____

Social Security____/___/_____Date of Birth____/____/_____Single___Married___Other___

Referred By:_____ Primary Care Provider:_____

Most recent Dr. visit___/___/___Next Dr. visit:___/___/___

RELATIONS & CONTACTS

Emergency Contact Name:_____Phone:_____

Spouse First:_____MI____Last Name:_____

Employer:_____Occupation:_____Phone:_____

PRIMARY RESPONSIBLE PARTY & INSURANCE BENEFITS

Copy of Insurance Cards_____ Copy of ID or License_____Copy of Rx_____

Responsible Party Name:_____Address:_____

1st Insurance Carrier:_____ Policy #:_____

2nd Insurance Carrier:_____ Policy #_____

_____Other Accident_____Employment Accident_____Auto Accident DOI_____

Insurance Coverage_____Deductible_____Copay_____Rollover Month_____

Policy Holders Name:_____Relationship to Insured_____

Other Insurance:_____

Employer at time of Accident:_____

Brief Description of Injury/Accident:_____

Attorney:_____Phone:_____

Address:_____

(OVER)

Release of Information ~ Payment Agreement

Cancellations ~ No Shows ~ Assignment of Benefits

Release of Information: I hereby authorize Advanced Rehab, PC to release my information to my referring provider, billing agency, my insurance company, AND:

1._____ 2._____ 3._____

Information will not be released to any other party without my permission.

Please initial each paragraph as acknowledgment and understood where indicated.

Payment Agreement: I understand that it is my responsibility to pay for all charges, regardless of insurance or other third-party coverage. I understand that I am expected to pay the balance due on my account each month. This applies even with services that are ongoing.

- Advanced Rehab will bill the insurance carrier provided by patient at their first visit; other insurance carrier information provided **after the initial visit** will be the responsibility of the patient to coordinate reimbursement for services rendered. If, Advanced Rehab agrees to bill another insurance carrier provided **after the initial visit** patient agrees to pay administrative costs for this service at $20 per hour. **Initial** _____
- My C0-payments are due at the time of service and my percentage of financial RESONSIBILITY IS DUE AT THE END OF EACH WEEK I AM TREATED unless other arrangements are made in writing. According to insurance law, if we are a provider for your insurance carrier we cannot balance bill. What that means is you are responsible for what your insurance carrier state is your responsibility. However, should you choose to have equipment, supplies or services your insurance carrier does not cover you agree to be responsible for those expenses (see below – **Additional Costs**). If I over-pay the bill, I will be reimbursed the amount that I overpaid upon EOB verification from insurance carrier. **Initial** _____
- I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physical therapist and/or his/her designated providers.
- I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
- I understand that I am financially responsible for all charges whether or not paid by my insurance. **Initial** _____
- I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 50% of the balance, including attorney/court costs **will be added** to the balance of my account.

Additional Costs: Insurance companies do not reimburse for some of the costs of your treatment. You may be charged/accountable for those items used in your care such as Trigger Point needles ($.20/needle), Theraband ($3.00/yard), Iontophoresis pads ($100.00/box). Some insurance carriers are not covering electrical stimulation. If your insurance carrier does not cover this expense and you choose to have this service, you are agreeing to pay for this service ($40/unit). **Initial** _____

Cancellations & No Shows: If during the course of treatment, should I cancel a scheduled appointment I will notify Advanced Rehab, PC *at least* 24 hours before the appointment so that the treatment time can be offered to someone who can benefit from the care. If I fail to give 24 hours notice of cancellation, I understand that I will be charged $40.00 that is not billable to my insurance. Three cancellations without rescheduling will result in discharged from physical therapy. If I do not provide notice and do not show for a scheduled appointment, I understand that I will be charged $80.00 for the missed appointment that is not billable to my insurance company. Two complete no shows will result in discharged from physical therapy. Advanced Rehab reserves the right to use discretion with this policy. We are here to help you and we cannot effectively do that without YOU! **Initial** _____

Insurance Complaint : I hereby give Advanced Rehab, PC permission to formally complain on my behalf to the State of Montana Insurance Commissioner in the event my benefit provider does not process my claims as required by Montana Law. **Initial** _____

Assignment of Insurance: I authorize payment of medical benefits to Advanced Rehab, PC.

Patient Signature:_____ Date:_____

Guardian:_____ Date:_____

Witness:_____ Date:_____