PIPELINE PHYSICAL THERAPY

PATIENT REGISTRATION FORM

PLEASE FILL OUT THE FORMS IN PRINT

PERSONAL INFORMATION

Patient Full Name: _____ Gender: ☐ Male ☐ Female Birth Date: _____ Age: _____
Preferred Name: _____ Social Security: _____ DL#:_____ Marital Status: _____
Residence Address: _____ City: _____ State: _____ Zip Code: _____
Mailing/Billing Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone#: _____ Cell Phone#: _____ Email Address: _____
Employer:_____ Occupation: _____ Work Phone#:_____
Emergency Contact Name: _____ Relationship: _____Telephone: _____
Preferred Method of Contact for reminder calls and other electronically generated messages:
(Please select only one option) ☐ Voice ☐ Text If Voice, please select preferred number: ☐ Home ☐ Cell ☐ Work

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RESPONSIBLE PARTY If Under 18, Parent / Guardian: _____ Relationship to Patient: _____
Parent / Guardian Social Security: _____ Parent / Guardian Date of Birth: _____
Telephone#: _____ Work #: _____

Do you have a prescription for a physician or provider for physical therapy? ☐ Yes ☐ No
If Yes, who is the referring physician? _____ Primary Physician: _____
Reason for your visit:_____ Return to Doctor Date:_____
Are you seeking physical therapy because of a work-related accident? ☐ Yes ☐ No An automobile accident? ☐ Yes ☐ No
If yes, list Claim Number: _____Adjuster/Case Contact: _____Phone:_____
Date of Injury: _____ How did this injury occur? _____ Fax: _____
Employer Address: _____ City: _____ State:_____ Zip Code:_____

PLEASE PRESENT YOUR I.D. AND INSURANCE CARDS TO THE FRONT DESK FOR COPYING

INSURANCE INFORMATION

(*to be completed even if insurance card is on file)*

Primary Medical Insurance

Insurance Co Name: _____
Policyholder/Subscriber Name: _____
Policyholder/Sponsor/Guarantor Birth Date: _____
Policy Holder/Sponsor/Guarantor SSN: _____
Policy Number: _____
Group Number: _____
Relationship to Patient: _____

Sponsor's/Subscriber's Address and Phone # if different from patient:
Address: _____
City:_____ State:_____ Zip: _____
Telephone: _____

Secondary Medical Insurance

Insurance Co Name: _____
Policyholder/Subscriber Name: _____
Policyholder/Sponsor/Guarantor Birth Date: _____
Policy Holder/Sponsor/Guarantor SSN: _____
Policy Number: _____
Group Number: _____
Relationship to Patient: _____

Sponsor's/Subscriber's Address and Phone # if different from patient:
Address: _____
City:_____ State:_____ Zip: _____
Telephone: _____

CANCELLATION POLICY

At Pipeline Physical Therapy, our mission is to provide world class rehabilitation. In order to accomplish this, attending scheduled appointments is vital for patient success. We understand that scheduling conflicts occur, and we will make every effort to accommodate you. We require 24 hours notice in the event of a cancellation. There is a $40 charge for a cancellation without proper notice. Your insurance will not cover the penalty amount and you will be responsible for this charge. Missed/late cancelled appointments prevent other patients the opportunity for an appointment and affect the consistency of your own rehabilitation program. The therapist will not be able to reschedule on short notices and must accommodate for lost work time. _____**Initials**

Continued on the other side

PIPELINE PHYSICAL THERAPY

PATIENT INFORMATION AND CONSENT FORM

BILLING
(when applicable, please initial below)

PRIVATE INSURANCE
_____ **INITIALS** If you belong to a preferred provider plan, we will accept payment as per the contract of that health plan. If there is a deductible amount, you are responsible for that payment of the deductible. If you have a copayment or percentage plan (coinsurance), you are responsible for the copay and/or percentage amount (coinsurance). As a courtesy, Pipeline Physical Therapy has verified my insurance benefits though this does not guarantee payment for services from the insurance company. If you are not aware of your physical therapy benefits, please let us know and we will inquire for you.

MEDICARE BENEFICIARIES
_____ **INITIALS** We will accept payment as determined by Medicare regulations. Medicare will pay 80% of charges after the deductible has been met. If you have a Medicare supplement, Medicare will bill them directly for you. If you do not have a Medicare supplement, you are responsible for the coinsurance amount.

WORKER'S COMPENSATION PATIENTS
_____ **INITIALS** We will bill the compensation carrier on your behalf. Please understand that if determination is made that your claim is not work related, you will be made responsible for all charges incurred. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It's also required that all missed visits are rescheduled.

NO INSURANCE / PRIVATE PAY
_____ **INITIALS** You are responsible for payment at the time of services rendered.

CONSENT FOR CARE AND TREATMENT
I hereby agree and give my consent to Pipeline Physical Therapy to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

NOTICE OF PATIENT INFORMATION PRACTICES: I have read and fully understand Pipeline Physical Therapy's notice of Information Practices.

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Pipeline Physical Therapy to release any protected health information (PHI) required in the course of my examination and treatment to the insurance company, or their affiliates, or which I provided the information.

I also authorize the release of appointment information left in a voicemail, answering machine, or text message and understand the level of privacy risk associated with these forms of communication.

HIPAA CONSENTS: In compliance with HIPAA regulations, I consent to the following individuals receiving verbal information regarding the billing of my account:

_____ Name/Relationship

_____ Name/Relationship

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY
I understand authorized personnel (including my physical therapist) from Pipeline Physical Therapy may communicate with me regarding scheduling/appointments, the treatment provided, home exercise programs, and education or informative content as it relates to my condition. I understand that my protected health information will not be communicated electronically. I understand that I have the opportunity to opt-out of all future communications at any time.

My signature below certifies that I have read, understand, and fully agree to each statement in the document.

Printed Name: _____ **Date:_____**

Patient / Guardian Signature: _____ **Date: _____**