PATIENT REGISTRATION FORM

❑ Patient ID card scanned and in Chart ❑ Returning Established Patient

Today's Date:	Primary Care Physician:

PATIENT INFORMATION- please fill out in entirety

PATIENT'S LEGAL NAME: Last: First: Middle:	DOB: / / Age:	Gender Documented with Insurance: ❑ Male ❑ Female

Cell Phone: ( )	Home Phone: ( )	Email Address:
If minor: Guardian's Cell Phone:	Guardian Home Phone:	Guardian Email Address:

May we send texts to confirm appointments and for communication: ❑ Yes ❑ No

Street Address or P.O. Box:

City:	State:	Zip Code:

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Windowed/Widower

Occupation:	Employer:
Is this a Worker's Comp Claim: ❑ Yes ❑ No	Is this an Auto Accident Claim: ❑ Yes ❑ No

Name of Emergency Contact (Guardian if Minor):

Phone: ( )	Relationship to Patient:

❑ I hereby grant authorization for the above listed minor to be examined and treated at Sports and Ortho without my presence after the initial visit and throughout the remaining duration of care. I accept financial responsibility for the listed minor throughout the duration of care.

Guardian Signature: _____

Do you have a primary care physician/family physician? : ❑ Yes ❑ No If yes, Name: _____

Please be aware that by law, we must inform your physician with your permission that you are being treated for physical therapy. I hereby grant permission to inform my physician listed above: (Patient Signature)_____

Referred to Clinic by or Chose clinic because (please check one box below):

❑ Dr. :_____	❑ Affiliation/sponsorship: _____

❑ Family	❑ Friend	❑ Close to Home or Work	❑ Google Reviews	❑ Insurance	❑ Other

If referred, Whom may we thank?

If you refer someone to our clinics and they let us know that YOU referred them, you will receive a gift card as a special thank you from Sports and Ortho

sports ortho
PHYSICAL THERAPY SPORTS MEDICINE

PATIENT INSURANCE REGISTRATION

INSURANCE INFORMATION- please fill out in entirety ☐ Insurance Card Scanned and in Chart			
Patient Name: (Last, First)			DOB:
Name of Primary Insurance:			
Subscriber's name:	DOB: / /	Group Number:	Policy Number:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Name of Secondary Insurance (if applicable):			
Subscriber's Name:	DOB:	Group Number:	Policy Number:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Person Responsible for Bill:			DOB:
Address (If different than Patient):			Cell/Home Phone: ( )
Is the Insurance Subscriber a patient at Sports and Ortho? ❑ Yes ❑ No			

MEDICARE PATIENTS ONLY:

Are you currently in Home Health: ❑ Yes ❑ No

Have you previously had physical therapy this calendar year? ❑ Yes ❑ No

Under Medicare guidelines, a Medicare Patient CANNOT receive Home-Health Services and Outpatient Physical Therapy treatment at the same time. You must inform our front desk immediately if this occurs. In the event that Medicare denies our claim because you were receiving Home Health Services concurrently with physical therapy treatments, you will be responsible for the full balance. (please sign below to acknowledge you have read and agree to these terms)

Financial Responsibility and Release of Information Agreement

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Sports and Ortho. I understand that I am financially responsible for any balance. By signing I authorize the release of any information required to process my claims.

Patient/Guardian Signature *Date*

Policy Agreement

Please initial at each policy and sign below

Patient Initials	HIPAA Policy
	I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan, and direct my treatment directly and indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physicians' certifications.
	Responsibilities
	I understand that receiving physical therapy care does involve treatment in an open area, there by not providing full privacy at all times. If you feel uncomfortable with discussing your medical history, current problem, or plan of care area in an open area, please notify your therapist before the assessment begins and accommodations will be made.
	Cancellations and Attendance
	ANY AND ALL cancellations must be made at least 24 hours in advance prior to your scheduled appointment. A charge of $50.00 will assessed to the patient for no shows and/or any late cancellations.
	Medical Necessity and Authorizations
	I acknowledge for today's and subsequent visits that I will assume full financial responsibility for services rendered if my insurance carrier denies, or does not cover my claim.
	Insurance Co-payments and Deductibles
	I understand that I am responsible to pay all co-pays at the time of service. I understand that I am fully responsible for timely payment of my deductible, no more than 30 days after my notification by my insurance and/or provider. I understand that if I need to make payments or arrange a payment plan that it is my responsibility to speak to the Front Office Staff about this option.
	Consent to Treat
	I do hereby agree and give my consent for Sports & Ortho Physical Therapy to furnish medical care and treatment to myself or the minor patient that I am the responsible guardian listed above considered necessary and proper in diagnosing or treating my physical condition.
	Benefit Assignment
	I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third-party payers to Sports and Ortho Physical Therapy. A photocopy of this assignments to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.
	Worker's Comp Patients **ONLY:**
	I do herby understand that if I do not attend scheduled physical therapy appointments that my no-show, cancellations, and missed appointments will be notified to my worker's comp case manager as my attendance is a requirement of my work duty.

Policy Agreement and Financial Responsibility Agreement

I attest that the above information is true to the best of my knowledge. I authorize Sports and Ortho to collect any of the above payments and policies that I have agreed to by initialing next to said policy. I understand that I am financially responsible for any balance owed to Sports and Ortho. By signing below, I agree to the above information and that all of my questions regarding these policies have been answered.

Patient/Guardian Signature *Date*

Video/Picture Release for Public Relations Promotion

On occasion Sports & Ortho Physical Therapy will have an opportunity to promote our organization and our programs. Such promotions will be in the form of media and marketing. We must obtain your written permission to photograph, video, audio tape, or write articles about our patients for Media/Public Relations authorization. This is a voluntary act and the organization cannot require you to sign this form. By signing this form you are agreeing to the Media/Public Authorization below. You will give Sports & Ortho Physical Therapy permission to photograph, video, audio tape, or write articles about you for media and marketing purposes.

1) I authorize Sports & Ortho Physical Therapy to disclose to media representatives and/or public affairs staff members protected health information and information about me, my condition, and/or treatment for purposes of publicity, promotion, education, or publication in print, broadcast, electronic, and social media. This authorization includes my likeness on photo, videotape, and digital media.
2) I understand that I have the right to revoke this authorization at any time.
3) I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Sports & Ortho Physical Therapy nor will it affect my eligibility for benefits.
4) I understand that I will not be compensated in any way for the taking or use of photographs, films, audio and/or videotapes, or the publishing of any article or information.
5) I understand that I may revoke this authorization at any time by notifying the owner of Sports & Ortho, Dahlia Fahmy at 312-225-3119 via a phone call or in writing to dahliafahmy@sportsandortho.net, but if I do, it will not have any effect on any actions Sports & Ortho Physical Therapy took before it received the revocation.

Name: (print)

_____

Signature authorizing consent:

_____

Date:

_____