PATIENT REGISTRATION

First Name: ___________________________ M.I. _____ **Last Name:** ___________________________

Date of Birth: _______ / _______ / _______ SSN: _________ - _________ - _________ Gender M / F

Marital Status: Single / Married / Divorced / Other

Mailing Address: ____________________________________ Home Phone: _______ - _______ - _______

____________________________________ Cell Phone: _______ - _______ - _______

Email Address: ______________________________________ Text Message Reminders? Y / N
(Reminders alert one day in advanced)

Employer Name: _______________________________________ *Cellphone Carrier: ________________

Employer Address: _____________________________________ Occupation: ______________________

MEDICAL INFORMATION

Referring Physician: __________________________ Primary Care Physician: _______________________

Area to be Treated: ______________________________ Date of Injury: ____________________________

Surgery? Y / N Date of Surgery: __________________________

HEALTH INSURANCE INFORMATION (MUST BE COMPLETED even if WC or Motor Vehicle)

Is Your Condition Related To: Employment Auto Sports Other?

Primary Health Insurance Company: ______________________ ID # _____________________________

Name of Primary Card Holder: __________________________ Relationship to Insured: ________________

Insured's Date of Birth: ______/______/______ Insured's SSN: _______-_______-_______

Person Responsible for Bill (if patient is under 18): ___________________________________

Do You Have **Secondary Health** Insurance? Y / N

Company: ________________ ID#__________________________ Who is the Insured: ________________

Relationship to Insured: __________ Their Date of Birth: _____/_____/_____ Their SSN: _____-_____-_____

Worker Compensation or Auto Insurance: Type: WC / AUTO

Name of Insurance: ____

Adjuster / Nurse Case Manager: _________________________ Phone Number: ______________________

Claim Number: ______________________________

ASSIGNMENT: I request that payment of authorized Medicare, Blue Cross, HMO's and/or all other commercial benefits be made directly to West Milford Physical Therapy Center, for any services furnished to me. I also understand that I am financially responsible for all co-pays, co-insurance and deductibles at the time of service. I authorize full payment from my credit card if balance has not been paid within 30 days of patient statement. I agree to reimburse WMPT the fees of any collection agency, which may be based on a percentage at a maximum of 35-50% of the debt, and all costs and expenses, including reasonably attorney's fees, we incur in such collection efforts. I too fully understand and agree with the HIPAA policy and Financial Agreement that was provided to me on my Initial Evaluation.

Credit Card #: ____ **Exp. Date:** __________________________

My signature indicates that I have read, understand and agree with the above statements.

Responsible Party Signature: ______________________________ Date: __________________

MEDICATION LIST

Name: ____ Date: ____________

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication Name	Dosage	Frequency (Circle One)	Method of Administration (Circle)
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______
		As needed Once Daily 2x Daily 3x Daily Other:_______	Oral Sublingual Topical Subcutaneous Injection Other:______

Patient Signature:
______________________________ Date: __________

Reviewed By:
___________________________ Date: __________

NAME: ____ **DATE:** ______/______/______

MEDICAL HISTORY

	Yes	No		Yes	No
Asthma, Bronchitis or Emphysema			Emotional / Psychological Problems		
Shortness of Breath / Chest Pain			Arthritis / Swollen Joints / Gout		
Coronary Heart Disease			Joint Replacement		
Pacemaker			Osteoporosis		
High Blood Pressure			Varicose Veins		
Heart Attack / Surgery			Sleeping Difficulties		
Stroke / TIA			Cancer or Chemo / Radiation		
Blood Clot / Emboli			Bowel / Bladder Problems		
Epilepsy / Seizures			Severe / Frequent Headaches		
Thyroid Trouble / Goiter			Vision / Hearing Difficulties		
Anemia			Dizziness / Faintness		
Infectious Disease (Ex. Lyme)			Latex Allergy?		
Osteoarthritis or Rheumatoid Arthritis			High Cholesterol?		
Diabetes?			Are you Pregnant?		

Do you have any of the following?

Smoking: Y / N Daily _____ Weekly _____ Alcohol: Y / N Daily _____ Weekly _____

Other Medical History:

____

____

____

____

____

Are you aware of your diagnosis? Y / N Are you aware of your prognosis? Y / N

Consent to Treatment

Following assessment by a licensed Physical Therapist, a treatment approach will be developed to address functional deficits. The treatment program may include scheduled visits at the Physical Therapy office implementing modalities, manual therapy techniques and an individualized program. Additionally, instruction for posture, movement mechanics and home exercises will be completed. My signature below signifies my consent to treatment as outlined by the Physical Therapist.

Patient/Parent/Guardian Signature: ________________________________ Date: _____/_____/_____

HIPAA Authorization / Financial Agreement

At this time, I would like to designate the following individual(s) as my personal representative and authorize them to receive total disclosure of my Protected Health Insurance information.

First and Last Name ____________________________ Relation ______________________ Phone Number ___________________

First and Last Name ____________________________ Relation ______________________ Phone Number ___________________

By signing below, I acknowledge that I have read the attached "HIPAA Privacy Policy". I understand that I may ask any questions about the "Privacy Policy" at any time.

I have also read, understand and agree to the "Consent for Disclosure of Medical Information" and to West Milford Physical Therapy's Office Policies regarding Co-Pays, Cancellations, No Shows, and Returned Checks.

I authorize payment of benefits to West Milford Physical Therapy for services rendered. **I understand that I am financially responsible for and hereby guarantee payment for all services rendered.**

If your insurance plan is subject to deductibles and coinsurances, we suggest you contact your insurance company with any questions. *Please be aware that **Medicare only covers 80% of physical therapy services**. If you do not have a secondary insurance that we participate with, **you will be responsible for the 20% of your bill that is NOT covered by Medicare.**

Patient Signature: ____ Date: _____/_____/_____
(If patient is a minor, legal parent or guardian must sign)

Please PRINT Patient Name: ____

Please keep the attached copy regarding HIPAA Privacy Policy/Financial Agreement

PATIENT COPY

HIPAA Privacy Policy

To provide Physical Therapy treatments, receive reimbursement for services, and provide associated health care services, certain medical information will need to be disclosed to others (e.g.: physicians, insurance companies, and third-party payers).

This information, known as Protected Health Insurance (PHI), is protected by the Privacy Rule, which requires this clinic to limit the use, disclosure of, and requests for such information. When an appropriate party requests PHI, only the minimum necessary amount of information to accomplish the intended purpose will be disclosed. This clinic follows specific verification procedures to determine the identity and authority of any person requesting PHI. You have the right to opt out of receiving fundraising communication.

Under the Privacy Act, all patients have the right to request restrictions on how this facility uses and discloses PHI. However, only if the provider agrees and signs such a written request will he/she be bound to such restrictions. The patient has the right to be notified should a breach of this agreement occur.

Additionally, a person authorized to act on behalf of the patient in making healthcare decisions will be considered the "personal representative" and will be treated the same as the patient, with respect to use and disclosure of the PHI. In most cases, the patient is deemed the "personal representative" with regard to the disclosure of any personal health information. Authorization is also required for disclosure of PHI for marketing purposes and disclosures that constitute a sale of PHI.

If payment in full for service is completed "out of pocket", the patient has the right to limit all disclosure to Medicare/other payers.

Patients have the right of access to the medical records and can obtain a copy following signed authorization within a reasonable time frame. A signed authorization for release of medical records is also necessary to disclose information to persons other than those previously described (e.g. an attorney). An accounting of all disclosures will be completed and can be made available upon request.

If you have any questions, please ask to speak to the Privacy Officer at this facility.

Thank You.

Consent for Disclosure of Medical Information

To carry out treatment, seek payment and complete other health care operations, certain protected health information may be used or disclosed. This information may include identifying information, physical condition, treatment, prognosis and charges.

All patients have the right to review the Privacy Policy of this facility to clarify all aspects regarding disclosures and use of protected health information. This policy is included on the reverse side of this page. The terms of the Privacy Policy of this facility are subject to change. Any revisions will be promptly posted and are available upon written request.

Every patient has the right to restrict the use and disclosure. Only if the covered entity (provider) signs an agreement to such restrictions will he/she be bound by them.

Your signature on the HIPPA Authorization form indicates consent to the release of protected health information for treatment, payment or other health care operations. You have the right to revoke your consent in writing at any time.

Any specific questions or concerns should be directed to the Privacy Officer of this facility.

Financial Agreement / Office Policies

CO-PAYS: Co-pays are payable at the time of your visit. No exceptions.

CANCELLATIONS: We ask you show consideration by notifying our office with advanced notice if you are unable to keep your appointment. **Failure to cancel your appointment at least a day in advance will result in a $25.00 fee applied to your account that is not payable by your insurance company.** Payment will be expected before future appointments will be honored.

NO SHOW: Failure to show up for your appointment will result in a $25.00 fee applied to your account that is not payable by your insurance company. Payment will be expected before future appointments will be honored.

RETURNED CHECKS: A fee of $35.00 will be applied to a patient's account for any returned checks.