

CHAPIN & HAVLICEK PHYSICAL THERAPY, LLC

<u>FOR OFFICE USE ONLY:</u>		
ACCOUNT # _____	PT ID# _____	DATE: _____
THERAPIST: _____ LOCATION: _____ NEW PATIENT: Yes ___		
RETURNING: Yes ___		
DIAGNOSIS: _____ MD: _____		

PATIENT REGISTRATION FORM (PAGE 1 OF 3)

Patient Name: _____ Date of Birth: _____

LAST FIRST M.I. (MM/DD/YY)

Social Security #: _____ - _____ - _____ Home Phone: _____ - _____ - _____ Cell Phone: _____ - _____ - _____

Street Address: _____ City: _____
State: _____ Zip: _____

Driver's License #: _____ State of Issue: _____ Sex: M ___ F ___ Marital Status: S ___ M ___ W ___ D ___

Emergency Phone #: _____ - _____ - _____ Name of Contact: _____
Relationship: _____

Patient is: minor ___ student ___ retired ___ self employed ___ currently employed ___ unemployed ___

<u>EMPLOYMENT SECTION</u>	
Employer Name: _____	Work phone #: _____ - _____ - _____ EXT. _____
Street Address: _____	City: _____
State: _____	Zip: _____
If you are a Student: Name of School: _____ Address: _____	

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HEALTH INSURANCE: Health Insurance information must be provided under all circumstances.

Please inform us of all insurance coverage that you carry at this time.

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Primary Health Insurance: _____ ID #: _____ Group#: _____

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Primary Insured Person's Name: _____ Date of Birth: _____

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Social Security # of insured: ____ - ____ - ____ Relationship to insured: Self ___ Spouse ___ Child ___ Other Dependent ___

Employer of insured: _____

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Street Address of Employer: _____ City: _____ State: _____ Zip: _____

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Secondary Health Insurance: _____ ID #: _____ Group#: _____

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Secondary Insured Person's Name: _____ Date of Birth: _____

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Social Security # of insured: ____ - ____ - ____ Relationship to insured: Self ___ Spouse ___ Child ___ Other Dependent ___

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Employer of insured: _____

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Street Address of Employer: _____ City: _____ State: _____ Zip: _____

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Medicare Patients must supply **DATE OF LAST VISIT TO M.D.:** _____ (MM/DD/YY)

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Please list all of your doctor's and their addresses to whom you would like reports sent:

HAVE YOU EVER RECEIVED PHYSICAL, OCCUPATIONAL THERAPY OR CHIROPRACTIC CARE FOR THIS CONDITION? Yes ___ No ___ This year? Yes ___ No ___

***** REQUIRED INSURANCE CLAIM INFORMATION*****
IS YOUR CONDITION: Medical Problem ___ Worker's Comp ___ Motor Vehicle Accident ___ Other accident ___
If an <u>accident</u> , Insurance Carriers <u>require</u> : Date of Accident/Injury: _____ State Accident took place in: _____
Is this a school sports injury? Yes ___ No ___ If yes, have you notified the school? Yes ___ No ___
School Insurance (if applicable): _____

<u>WORKER'S COMPENSATION:</u>
Has this injury been reported to your employer? Yes ___ No ___
Is this injury disputed as Worker's Compensation by employer? Yes ___ No ___
Company Name: (at time of injury) _____
Company Address: _____ City: _____ State: _____ Zip: _____
W/C Insurance: _____ Claim#: _____ Phone#: _____ - _____ - _____
Adjuster: _____ Nurse: _____

<u>AUTOMOBILE ACCIDENT SECTION:</u>

Has the accident been reported to your AUTO INSURANCE Company? Yes ___ No ___
Do you have an attorney for this accident? Yes ___ No ___
Is this accident/injury currently a lawsuit? Yes ___ No ___
<i>If not currently a lawsuit, if at any time in the future this becomes a lawsuit, it is the patient's responsibility to notify this office of all attorney information regarding representation in this accident.</i>
Name of Auto Insurance Company: _____ Claim#: _____
Company Address: _____
we will need a copy of auto insurance card for your chart
Policy #: _____ Policy Holder: _____
Patient is policy holder's: Spouse ___ Child ___ Other Dependent ___ Self ___ No relation ___
Does your Auto Insurance Policy provide <u>medical coverage</u> (med-pay): Yes ___ No ___ Unsure ___
Are Auto Medical Benefits exhausted for this auto accident: Yes ___ No ___ Unsure ___
Insurance Adjustor's Name: _____ Phone: _____ - _____ - _____ Ext: _____

ATTORNEY INFORMATION: Complete for any litigation pertaining to injury.
Attorney Name: _____ Phone: _____ Ext. _____
Attorney Address: _____ City: _____ State: _____ Zip: _____

*****CHAPIN & HAVLICEK PHYSICAL THERAPY, LLC FINANCIAL POLICY*****

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Registration/Insurance Form before seeing the therapist. This is page 3 of 3 Intake documents required.

Co-Pays are due at time of service: As you arrive for each appointment, please check in at the front desk and pay your copay. You are responsible for payment of all copays, deductibles and co-insurance associated with your insurance plan.

Regarding Insurance – The balance of your account for treatment **rendered is your responsibility whether reimbursement from other sources such as insurance coverage, workers compensation, motor vehicle insurance, or litigation may exist.**

We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. **Please be aware that some, and perhaps all of the services provided, may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance carrier programs.**

Changes in Your Insurance Coverage – It is the patient’s responsibility to inform this office of any and all changes of insurance coverage during the course of treatment. It is your responsibility to inform us that your insurance coverage is about to change so that we can verify your benefits and obtain prior authorization as required. Failure to provide this information will result in the patient being responsible for payment of all non-covered and/or unauthorized services.

Usual and Customary Rates – Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

Referral - As per your coverage, it is the patient’s responsibility to obtain a referral for physical or occupational therapy. No referral on file may result in denial of insurance coverage for some or all of your treatment received. Please contact your insurance carrier immediately and review your insurance contract requirements for your plan. Chapin & Havlicek Physical Therapy does not accept responsibility for any insurance carrier errors or misinformation supplied to either the patient or Chapin & Havlicek Physical Therapy, LLC.

Authorization Received – Authorization to treat received from your insurance carrier, does not guarantee payment for services rendered. **Should there be a portion established by your insurance carrier as “due from patient,” that balance is your responsibility.**

Adult patients – Adult patients are responsible for full payment of their account regardless of other reimbursement possibilities.

Minor Patients – The parents (or guardians of the minor) are responsible for full payment of the minor child’s account regardless of other reimbursement possibilities.

Fee for NSF Checks – There is \$25.00 charge for Non-Sufficient Funds Checks received as payment from patients.

Interest Charge – Interest automatically is accrued to accounts for unpaid charges over 90 days past due at 1.5% per month.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand the Financial Policy.

PATIENT (Responsible Party)

SIGNATURE: _____

DATE: _____

PAYMENT AUTHORIZATION
I authorize payment of medical benefits to the supplier, Chapin & Havlicek Physical Therapy, LLC for services rendered.

PATIENT (Responsible Party)

SIGNATURE: _____

DATE: _____

PATENT RELEASE OF INFORMATION
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below. (Reference HCFA Health Insurance Claim Form Box 12)

PATIENT (Responsible Party)

SIGNATURE: _____

DATE: _____

To our patients: Please provide us with your insurance cards and license to be copied for your chart. If at any time you would like to have a member of our insurance staff meet with

**you privately to discuss your insurance or account balance, please request at the front desk.
Our staff would be happy to assist you in the any way possible. Thank you.**