**PRES Physical Therapy Registration Information**

**Date:_____** **Account # _____**

**Patient Name:_____ SS#_____**
Last First Initial

**Street Address:_____**
**City:_____ State:_____ Zip:_____**
**Home Phone # _____ Work Phone # _____**
**Sex: M F Age:____ Birthdate:_____ Marital Status: Single , Married , Other**
**Employment Status: Employed , Student; Full-Time , Part-Time**
**Patient Employed by _____**
**Employer Address_____**
**_____Occupation_____**

**Insured Name:_____ SS#_____**
Last First Initial

**Street Address:_____**
**City:_____ State:_____ Zip:_____**
**Home Phone # _____ Work Phone # _____**
**Sex: M F Age:____ Birthdate:_____ Marital Status: Single , Married , Other**
**Employment Status: Employed , Student; Full-Time , Part-Time**
**Insured Employed by _____**
**Employer Address_____**
**_____Occupation_____**

**Family Physician:_____ City_____ Office#_____**
**Referring Physician:_____ City_____ Office#_____**

**Primary Insurance _____ Phone # _____**
**Insured Name:_____ Insured ID # _____**
**Plan Name or # _____ Group # _____ Claim # _____**
**Patient relationship to the insured _____**

**Secondary Insurance_____ Phone #**
**_____**
**Insured Name:_____ Insured ID # _____**
**Plan Name or # _____ Group # _____ Claim # _____**
**Patient relationship to the insured _____**

**Is your condition related to employment ( current or previous ) ? YES NO**
**Contact Name at work :_____ Phone # _____**
**Is your condition related to an automobile accident ? YES NO State _____**

**In case of an Emergency , who should be notified ? _____**
**Home # _____ Work # _____**
**Relationship to the patient _____**

# ACKNOWLEDGMENT OF PRIVACY PROCEDURES

1. **Consent for Release and Use of Confidential Information:**
   I have read the PRES Physical Therapy policy on Confidential Information.

   Signed X_____ Date _____

2. **Release of Information:**
   I authorize PRES Physical Therapy to release medical account information to my insurance carrier(s) to process my medical claims, as needed.

   Signed X_____ Date _____

3. **Assignment of Benefits:**
   I recognize and accept full responsibility for all professional services rendered and further authorize the insurance carrier(s) to pay benefit directly to this clinic if a balance is due.

   Signed X_____ Date _____

4. **Missed Appointment Policy:**
   I have read and understand the PRES Physical Therapy, Missed Appointment policy.

   Signed X_____ Date _____

(See reverse and attached forms for policies)

# PRES PHYSICAL THERAPY POLICIES

I hereby give permission to be treated by PRES Physical Therapy for therapy services. Therapy services have been explained to me; I understand this treatment and explanation and approve of said treatment.

The policy of this clinic is that payment is due at the time of service. Insured patients are expected to take care of their fees as services are rendered. Your clear understanding of our financial policy is important to our relationship. Your assistance in complying with our payment policies will help control our overhead expenses, thereby keeping fees reasonable.

Patients who carry health care insurance should remember that professional services are rendered to and charged to the patient and not to the insurance company. When we file a claim for you, you will receive a statement each month if your account has a balance due. Please understand that the insurance carrier may pay less than the actual bill for services. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed benefit/claim. You are responsible for payment of your account within the limits of our office credit policy.

If, for any reason, your account is referred to our collection agency, you will be responsible for all collection costs, court costs and reasonable attorney's fees.

If a carrier should deny coverage, you will be responsible for the account. Failure to keep your account current may result in PRES Physical Therapy being unable to provide additional services. Credit may be extended upon request in cases of sizable balances. We accept cash and checks.

If your insurance card has not been issued to you by the time of your visit, you will be treated as a self-paying patient; payment will thus be expected at the time of the visit and the claim will be submitted for you when we receive a card. Please be sure to notify our office immediately should you change medical insurance carriers, home address or telephone number.

As a client of PRES Physical Therapy your signature is required below as acceptance of our office policies and as acknowledgement that you have been advised of these policies. In addition, your signature will service as authorization to release medical account information to your insurance carrier(s) to process your medical claims, as needed.

Your signature also denotes that you recognize and accept full responsibility for all professional services rendered and further authorizes the insurance carrier(s) to pay benefits directly to this clinic if a balance is due.

It is our policy that the parent or guardian accompanying the child to the clinic will be responsible for full payment of the bill. Thank you for you understanding. Please let us know if you have any questions or concerns.

## Consent for Release and Use of Confidential Information

I hereby give my consent to PRES Physical Therapy to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to PRES Physical Therapy. I also understand that I will not be able to revoke this consent in cases where PRES Physical Therapy has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the PRES Physical Therapy Office.

## PATIENT MISSED APPOINTMENT POLICY

We strive to provide with the utmost professionalism and excellence of service. Our commitment to your well-being and the gain of your physical abilities is something that every one in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a 24 hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform the physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

### Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by PRES Physical Therapy for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct healthcare operations of PRES Physical Therapy. I understand that diagnosis or treatment of me by PRES Physical Therapy may be conditioned upon my consent as evidenced by my signature or this document I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. PRES Physical Therapy is not required to agree to the restrictions that I request, the restriction is binding on PRES Physical Therapy.

I have the right to revoke this consent, in writing, at any time, except to the extent that PRES Physical Therapy has taken action in reliance on this consent. My “protected health information” means health information, including demographic information collected, from me and created or received by my physician, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present and future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review PRES Physical Therapy’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of PRES Physical Therapy. The Notice of Privacy Practices for PRES Physical Therapy is also provided in the reception area. This Notice of Privacy Practices also describes my rights and PRES Physical Therapy’s duties with respect to my protected health information.

PRES Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy practices by calling the office and requesting a copy be sent in the mail or asking for one at the time of my next appointment.

**Consent Form Definitions [to be printed on reverse side of form]**

"Health care operations" refers to a large number of activities, including:

1) Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3) Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5) Business planning and development, such as conducting cost management and planning-related analysis related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6) Business management and general administrative activities including but not limited to: (a) management activities relating to HIPAA privacy rule compliance; (b) customer services, including the provision of data analysis for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer; (c) resolution of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of healthcare. These activities referred to in this definition relate to the individual to whom health care is provided and include, but are not limited to:

1) Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2) Billing, claims management, collection activities, obtaining payments under a contract for reinsurance, and related health care data processing;
3) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4) Utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
5) Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information