# OrthoCare Physical Therapy and Sports Rehabilitation

## PATIENT REGISTRATION FORM

**Last Name: _____ First Name: _____ Male ❑ Female ❑**

**Date of Birth: _____ Age: _____ Social Security Number: _____-_____-_____**

**Marital Status: Married ❑ Divorced ❑ Single ❑ Widowed ❑ Other ❑**

**MAILING ADDRESS**

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

**E-mail Address: _____**

**CONTACT INFORMATION**

**Home Phone #: _____ Work #: _____ Cell #: _____**

**Responsible Parent or Guardian if Patient is under 18: _____**

**Emergency Contact: _____ Phone #: _____ Relation to patient: _____**

**Referring Physician: _____ Phone #: _____**

**Primary Care Physician: _____ Phone #: _____**

**Email Address: _____**

***Primary Insurance Information***

****All information pertains to the policyholder****

**Insurance Name: _____ ID #: _____**

**Policy Holder: _____ Relationship to patient: _____**

**Address:** (if different from patient) **_____**

**Social Security #: _____-_____-_____ Date of Birth: _____ Occupation: _____**

***Secondary Insurance Information***

****All information pertains to the policyholder****

**Insurance Name: _____ ID #: _____**

**Policy Holder: _____ Relationship to patient: _____**

**Address:** (if different from patient) **_____**

**Social Security #: _____-_____-_____ Date of Birth: _____ Occupation: _____**

***Worker's Compensation or No Fault Insurance only***

**Insurance Company Name/: _____**
**Address**: _____ **City**: _____ **State**: _____ **Zip**_____
**Contact Name**_____ **Phone**_____ **Fax:** _____
**WCB**: _____ **CarrierCase#**: _____ **Claim/File#**: _____
**Policy#:**_____**Date of Accident**_____**Policy Holder**:_____

**I hereby authorize the release of any medical information necessary to process my insurance claim and request direct payment be made to OrthoCare Physical Therapy and Sports Rehabilitation, PC. I authorize the physical therapists to proceed with my care and I understand I will be responsible for ALL charges not covered by my insurance including co-payments, co insurances and deductibles. Any such payment will be required at the time of services rendered. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions and if said referrals are not obtained, I am responsible for charges not covered under the referral.**

**Patient (Parent/Guardian) Signature: _____ Date: _____**

# Financial Policy and Patient Guidelines

1. **I understand that my co-pay, co-insurance and/or deductible are due at the time of my visit.**

2. **I understand that I am responsible for all charges not covered by my insurance and that my account may be placed in collections and that I am responsible for all fees associated with such actions.**

3. **If a check on my account is returned from the bank, I will incur a $25.00 service charge.**

4. **I understand OrthoCare may place a 21% interest rate on all unpaid balances past 90 days.**

5. **In order to achieve maximum benefit from your rehabilitation program, it is imperative that you attend your physical therapy appointments and follow your home instruction program. *(Compliance to <u>your</u> physical therapy program is the key to <u>your</u> recovery).***

6. **I understand I will incur a $25.00 service charge for any appointments that are missed without a 24-hour notification to the office. This amount will be due at your next visit in addition to your regular co-pay or co-insurance amount. *(It would be fraudulent to submit this fee to your insurance carrier.)***

7. **I understand it is my responsibility to schedule appointments at least one to two weeks in advance.**

8. **OrthoCare Physical Therapy and Sports Rehabilitation, PC reserves the right to reschedule an appointment if I am 15 or more minutes late.**

9. **If three or more consecutive appointments are missed any time during my treatment, all remaining scheduled appointments may be removed. I will be asked to call and check availability for the day I plan to attend.**

**Your cooperation is greatly appreciated. We look forward to working with you to obtain optimal outcomes from your rehabilitation program.**

**I hereby verify that I have read and understand the above financial policies and patient guidelines for the office of OrthoCare Physical Therapy and Sports Rehabilitation, PC.**

**Signature: _____**

**Patient Name: _____Date: _____**

**By refusing to sign the above document, OrthoCare Physical Therapy and Sports Rehabilitation, PC has the right to refuse to treat the patient unless it is an emergency.**

**Reason Patient refused to sign: _____**

**Witness: _____ Date: _____**