

Elite Sports and Physical Therapy

PATIENT REGISTRATION

Today's Date ___/___/___ Auto Accident ___ Worker's Comp ___ Date of Injury ___/___/___

Name _____ Injury Area _____

Street Address _____ P.O.Box/Apt # _____

City _____ State _____ ZIP _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____ Cell Phone _____ - _____ - _____

Male or Female Date of Birth ___/___/___ E-Mail _____

How did you hear about Elite Physical Therapy? Referred by Doctor Referred by Friend Drive By Website

Direct Mail Fitness Center Member Previous Patient Other: _____

Employer Information (Must complete for Worker's Comp Claims)

Employer _____

Address _____
Street City State Zip

Physician Information

Referring Physician Name _____

Primary Care Physician Name _____

Have you had physical therapy for this injury before? N Y When/where _____

Date you will return to your Doctor ___/___/___

MVA or Work Comp Claim Information

Claim Number _____ Insured Name _____

Insurance Company Name _____

Claims Adjuster _____ Phone _____

ATTORNEY: Name & telephone number _____

Primary Health Insurance Information

Insurance Name _____ Subscriber Name _____

Subscriber Birth Date ___/___/___ Patient relationship to subscriber _____

Subscriber Address _____
Street City State Zip

ID Number _____

Secondary Health Insurance Information

Insurance Name _____ Subscriber Name _____

Subscriber Birth Date ___/___/___ Patient relationship to subscriber _____

Subscriber Address _____
Street City State Zip

ID Number _____

CONSENT TO TREATMENT

I hereby authorize the professional staff at **Elite Sports and Physical Therapy** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I further consent to have my minor child treated by the staff of **Elite Sports and Physical Therapy** while I am not physically in the facility.

Patient Name (Printed)

Patient Signature

Date

Parent / Guardian Name (Printed)

Parent / Guardian Signature

Relationship

Witness

Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: **Elite Sports and Physical Therapy** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **Elite Sports and Physical Therapy** complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPAA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPAA guidelines.

Patient Name (Printed)

Patient Signature

Date

Parent / Guardian Name (Printed)

Parent / Guardian Signature

Relationship

Witness

Date

Elite Sports and Physical Therapy

Please choose your preference in receiving appointment reminders by checking ONE of the designated boxes below.

Email Reminders

If you prefer email appointment reminders, please provide your email address.

Email Address: _____

Text Message Reminders

If you prefer text message appointment reminders, please circle your cell phone carrier.

AT&T Verizon Sprint T Mobile Other:

**Normal text messaging rates may apply.*

Emergency Contact Name _____

Emergency Contact Phone # _____

Relationship _____

CANCELLATION POLICY

Should you need to cancel your appointment please note that we require a

24-HOUR ADVANCED NOTICE

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however we understand that there may be times when you cannot contact us and are unable to keep your appointment. If this happens please contact us at your earliest convenience to confirm your next appointment. Should you miss an appointment and not afford us the courtesy of a 24-hour advance notice so we can offer your appointment slot to another patient, **we reserve the right to charge you a fee.**

CANCELLATION FEE: \$25.00; NO SHOW FEE: \$40.00

If you miss three (3) consecutive appointments we will:

- Notify your physician and will require a new referral in order to continue your treatment
- At the discretion of the physical therapist, you may be discharged from therapy

Patient / Guardian Signature

Date