For Office Use

CFD Initials: _____

INDIANA PHYSICAL THERAPY
REGISTRATION FORM

PATIENT INFORMATION

Patient's Name First:	M.I.:	Last:	
Address:	City:	State:	Zip:
Home Phone: ( )	Cell Phone: ( )	Email:	
Date of Birth:	SSN:	Gender:	
Marital Status: (Circle One) Single / Married / Other	Spouse's Name:		
Patient Status: (Circle One) Employed Full-Time / Full-Time Student / Part-Time Student			
Employer:	Work Phone: ( )		
Date of Injury:	Place (State) of Injury:		
School Sports Injury: (Circle One) Yes / No	Name of School:		
Emergency Contact:			
Relationship:	Phone: ( )		

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD

Primary Insurance Company:		
Name of Insured:	Date of Birth:	SSN:
Relationship to Insured: (Circle One) Self / Spouse / Minor / Other		
Secondary Insurance Company (If Applicable):		
Name of Insured:	Date of Birth:	SSN:
Relationship to Insured: (Circle One) Self / Spouse / Minor / Other		

RESPONSIBLE PARTY/GUARDIAN INFORMATION

Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Relationship to Insured: (Circle One) Spouse / Child / Other	Date of Birth:		
Employer:	Work Phone: ( )		

MEDICARE PATIENTS ONLY - Medicare will pay for physical, occupational, or speech therapy services as long as treatment remains medically necessary. We will present an ABN (Advance Beneficiary Notice) to you at the time treatment is not medically necessary. This will allow you to decide if you want to continue with treatment knowing that these services will become your responsibility.

Have you received physical, occupational, or speech therapy services this year?

(Circle One) Yes / No Where did you receive these services? _____

Are you currently receiving home health care?

(Circle One) Yes / No Who is your home health care provider? _____

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Indiana Physical Therapy and hereby authorize and give my consent for IPT to furnish physical therapy care and treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for Indiana Physical Therapy to

treat _____ (minor's name) while I am not present.

Patient/Guardian/Responsible Party Signature:		***Date:***

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

PRIVACY NOTICE and RELEASE OF MEDICAL INFORMATION: A Notice of Privacy Practices (NPP) is available for your review or you may take it with you. The NPP describes Indiana Physical Therapy's comprehensive efforts to protect the privacy of your personal health and financial information. The NPP also describes how such information may be used, released or shared under the Health Insurance Portability and Accountability Act (HIPAA).

Initials

ATTENDANCE, CANCELLATION and NO SHOW: Attendance at your therapy visits is your most important responsibility because it can make the difference between whether or not you succeed in your treatment. While we understand you may need to cancel an appointment because of unforeseen circumstances, we do require at least 24 hours notice of cancellation. There is a $25 charge for cancellation without prior notice or for not showing for your appointment. This charge is not covered by insurance, and you are required to pay this fee personally. In the event of excessive cancellations or no shows, your therapist has the discretion to discharge you from therapy.

Initials

FINANCIAL RESPONSIBILITY: As a courtesy to you, Indiana Physical Therapy will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. Indiana Physical Therapy is not responsible for problems between the patient and insurance carrier, nor can IPT intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. If you fail to provide us with your insurance information and your insurance company's timely filing limit has passed, we will not file your medical insurance claims and you will be responsible for those dates of service. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, IPT requires payment by the patient for any equipment/supply at the time the order is placed. IPT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. Indiana Physical Therapy accepts credit/debit cards or personal checks as payment options. In the event payment is returned for insufficient funds, Indiana Physical Therapy complies with Indiana Code 26-1-3.1-502.5 $20 plus the amount charged by the depository institution will be applied to your account.

Visit Limit: if your insurance plan has a visit limit for physical therapy we will obtain a quote of visits used. This information is just a quote; which may be inaccurate at the time of our phone call. It is your responsibility to know how many visits have been used. Any visits past the visit limit will become patient responsibility at IPT's self pay rate.

Initials

CONSENT TO SHARE CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize Indiana Physical Therapy to share any and all of my medical/billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

PATIENT AUTHORIZATION

- By my initials and signature I understand these policies and my financial obligations for services rendered.
- I hereby assign payment of benefits by my insurance company to Indiana Physical Therapy, and I accept responsibility to ensure my insurance carrier makes payment on my account within 60 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.
- I hereby agree to pay any office visit/co-payment charges with each visit.
- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ Date: _____

Parent/Guardian/Guarantor: _____ Date: _____