



## PATIENT REGISTRATION

Date \_\_\_\_\_

CHART # \_\_\_\_\_

Patient \_\_\_\_\_ Nickname \_\_\_\_\_  
*FIRST MIDDLE LAST*

Address \_\_\_\_\_  
*STREET/PO BOX CITY STATE ZIP*

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail \_\_\_\_\_ Social Security # \_\_\_\_\_ Gender:  M  F

Date of Birth \_\_\_\_\_ Marital Status:  Single  Married  Divorced  Widowed

Employment Status:  Full Time  Part-Time  Not Employed  Retired  Student

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Primary Care Doctor \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

### IF YOUR INJURY WAS **JOB RELATED**, FILL OUT THIS SECTION

Employer when injured \_\_\_\_\_ Date of Injury \_\_\_\_\_

Employer's Workers Comp. Carrier \_\_\_\_\_ Claim # \_\_\_\_\_

Workers Comp. Carrier Address \_\_\_\_\_

Workers Comp. Carrier Phone \_\_\_\_\_ Claim Status:  Open  Closed  New  Disputed

### IF YOUR INJURY WAS FROM A **MOTOR VEHICLE ACCIDENT**, FILL OUT THIS SECTION

Your Auto Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

Auto Insurance Carrier Address \_\_\_\_\_

Name of Insured \_\_\_\_\_ Date of Injury \_\_\_\_\_ Claim # \_\_\_\_\_

Adjuster Name \_\_\_\_\_

### FOR ALL OTHER **INSURANCE CLAIMS**, FILL OUT THIS SECTION

Primary Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_

Primary Insurance Company Address \_\_\_\_\_

Name of Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

FOR **SECONDARY INSURANCE** COVERAGE, FILL OUT THIS SECTION

Secondary Insurance Company Name \_\_\_\_\_ Phone \_\_\_\_\_  
Secondary Insurance Company Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Payment Agreement**

I understand that payment for all therapy services is my responsibility regardless of the insurance or other third party coverage.

We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We will be happy to process your insurance claims and request assignment of private benefits unless you pay in full at the time of treatment. It is your responsibility to understand your insurance policy and coverage. Should insurance benefits paid to us result in a credit balance on your account, your money will be promptly refunded to you or your insurance company.

A monthly statement will be sent to you. We accept payment by cash, check or money order. Past due accounts, over 60 days, will be subject to a monthly rebilling charge. Legal procedures for collection of past due accounts will be initiated if non-payment of account extends beyond 90 days. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect past due accounts.

For claims in pending litigation (or dispute as to the responsible party), prior written arrangements must be made for consistent payment of the account balance as we are unable to wait for resolution of a dispute. We reserve the right to discontinue treatments if reasonable, regular payments are not made or if the balance becomes untenable.

Medicare – we accept Medicare assignment and we will bill Medicare for you. Medicare pays 80% of the approved amounts and does not allow us to write off any portion of the 20% co-pay or deductible. Please understand that payment in full for all charges is your responsibility.

I authorize payment of medical benefits to Apex Physical Therapy, LLC, and I have read and understand this payment agreement.

**Consent to Treat and Authorization to Release Information**

I voluntarily consent to *evaluation and treatment* by Apex Physical Therapy, LLC and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

I authorize the *release of information* acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or other third party payer.

I authorize *phone messages* regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

A copy of this facility's *Statement of Privacy Notice* has been provided to me.

**“No Show” Policy**

Any patient who fails to arrive for a scheduled appointment without canceling the appointment less than 24 hours prior to the scheduled time is considered a “no-show.” A no-show patient is charged a fee, as set by Apex, for failure to show. A patient who consistently fails to present themselves for scheduled appointments is considered a chronic no-show. A patient who is a no-show more than three times is dismissed from Apex.

By signing below, I certify that I have read the *Payment Agreement, Consent to Treat and Authorization to Release Information, and “No Show” Policy* sections above and agree to all statements contained therein.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Responsible Party \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_  
(if different than patient)