REGISTRATION FORM

Date:_____________________________________

PERSONAL INFORMATION

Name:____Telephone #'s: (Hm):________________________
Name of Parent or Guardian if applicable:____
Address:____ (Wk):________________________
_____________________________________Zip:_____________ (Cell):________________________
S.S.#________________________________E-mail Address:____
Date of Birth:______________________________Age:__________ Male _____ Female _____
Marital Status (circle one): M S D SEP W If married, Spouse's Name:___________________________
Are you? Employed ______ Student ________ Employer/School Name:__________________________
Is your injury a result of an accident? Yes ______ No ________
If yes, date of accident:___________________________ State of accident:____________________

PATIENT BILLING INFORMATION

I have been advised that H/S Therapy Associates has contacted my insurance plan and that my benefits for outpatient physical therapy care are:____
____

Any amounts I am responsible to pay under your plan will be billed to you with a copy of the explanation of benefits from your insurance carrier. You will have 30 days from date of the bill to make a payment. As long as you continue to make monthly payments towards your account balance, no services charges will be assessed. Should you fail to make monthly payments; a 5% monthly service charge will be assessed. If the above notes a per visit co-payment, I agree to pay this co-payment at the time of service rendered.

I understand that all information provided by any member of the H/S Therapy Associates staff regarding my insurance coverage is not a guarantee of my medical benefits. I will not hold H/S Therapy Associates responsible for any misinformation they may receive from my insurance company regarding coverage for outpatient physical therapy care. I have been advised to contact my insurance company directly to verify my benefits for outpatient physical therapy care.

CANCELLATION AND NO-SHOW POLICY

In the event of a cancellation, we require a phone call prior to your visit time. When you call, have an alternative time in mind to assure that you are seen the prescribed number of visits that week.

There is a $20 charge for a cancellation without proper notice or for a not showing for a scheduled visit. This charge will not be covered by your insurance company, but will have to be paid by you personally.

PATIENT RELEASES

I hereby authorize H/S Therapy Associates, Inc. to: 1) provide me with physical therapy treatments and 2) to furnish the above named insurance company(s) with any medical information regarding this injury that may be necessary to process all claims relative to the physical therapy treatments received. I request that payment of authorized insurance benefits for the physical therapy treatments I receive at H/S Therapy Associates, Inc. be made on my behalf directly to H/S Therapy Associates, Inc. I understand that I am legally responsible for any charges for physical therapy services received at H/S Therapy Associates, Inc. which are unpaid by my insurance coverage and deemed by them to be my personal responsibility to pay. I agree to pay H/S Therapy Associates a $25.00 processing charge for any check that I issue that is returned by the bank. Further, if my account is referred for collection, I understand that I will be responsible for any and all collection costs, including court costs and reasonable attorney's fees if applicable.

Signature: ____ Date: _____________________________

HIPPA-PRIVACY NOTICE

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

Signature:____Date:______________________