Patient Express Registration

Today's Date:

1. Patient Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ ZIP _____

(_____) Home Phone _____ (_____) Cellular _____ ● Email Address _____

Occupation _____ Employer Name _____ (_____) Phone # _____

Emergency Contact Person _____ (_____) Phone # _____ If Patient is a MINOR: Parent/Guardian Name and Signature Here _____

Social Security # _____ Date of Birth ____/____/____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (___Total or ___Temporary) ❑ Student (___P/T___F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO/PERSONAL INJURY: Date of accident: ____/____/____

❑ WORK INJURY: Complete all information below.

Date of injury: ____/____/____

Your company HR person name _____

Insurance adjustor name _____

Insurance adjustor PH# _____

❑ NO INJURY: What do you think may have caused it?

I have already had . . .

❑ **SURGERY**: When and what type?

❑ **PHYSICAL THERAPY BEFORE**: When and where?

❑ **HOME HEALTH CARE**: Are you still receiving it? YES NO

❑ OTHER care: What?

3. Payment Info

(check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to . . .

__ Have you deal directly with them. I will assign my benefits to you by completing the **"Assignment of Benefits Form"** (Fees may apply in some cases). The following information is required prior to 1st visit.

My coinsurance/copay is $_____

My deductible is $_____

__ I will pay the entire bill at the time of service. And I'll get reimbursement from my insurance company on my own. (Ask the front desk person for details)

❑ **WORKERS COMP** . . .

You must have all info provided under "My Condition...".

- Case Worker (name & number)
- Claim number
- Claim mailing address and phone number

❑ **NO INSURANCE** and would like to . . .

__ Pay by cash, check or credit card

4. Referral Info

How did you hear about us?

❑ Friend or Family: ❑ Brochure: Give details:

❑ Internet: ❑ Insurance/Directory:

❑ Advertisement: ❑ Other:

❑ Physician/Dentist/Chiropractor/Nurse: Give details below.

Referring Physician/Person's Name _____

City _____ State _____

Phone # _____

Signature: _____

Important Company Policies for a Successful Relationship

Late Policy

Please be on time for your appointment. Being on time for your appointment ensures optimal care of the patient. If you are not on time for your appointment we may request you reschedule at a time we can better provide patient care.

24-Hour Advance Notice

If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Please be prepared to to have an alternative time in mind to make up the canceled appointment to adhere to the frequency of visits per week your physician has prescribed.

Copays are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment. It is unlawful to waive copays or deductibles. New Stride offers Care Credit for those patients requiring a payment plan.

Financial Policy

We accept cash, person checks, money orders and credit card payment. If a check is returned from your bank as insufficient, we will require that you make a payment in cash. In addition, a service fee of $35 will be added to your balance. Your insurance policy is a contract between you and your insurance company. New Stride Physical Therapy, Inc. is not a party to that contract. While we do file insurance claims for our patients, any charges not covered by your insurance plan is your responsibility. Our relationship is with you and not your insurance carrier. Outstanding balances 60 days or older will be referred to our collections agency.

Assignment of Benefits

Authorization of payment: I hereby assign all benefits directly to New Stride Physical Therapy, Inc. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

No-shows are bad

No-shows are bad. The patient does not receive the treatment needed to recover from an injury or pain. The Physical Therapist or Massage Therapist has a vacant space on their schedule that was reserved for you personally. Another patient could have been scheduled for treatment if there had been proper 24-hour advanced notice.

HIPPA

I have read the Privacy Notice and understand my rights contained in the notice. I understand that a hard copy of the HIPPA policy is available to me at any time.

Cell phones must be on silent

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode. Thank you.

Supervise children at all times

Please supervise children at all times. Children are not allowed to play on Physical Therapy equipment and must be courteous to other patients receiving care in the clinic.

Informed Consent

The patient gives the Physical Therapist permission to the evaluation and treatment. All treatment is determined after the initial evaluation and deemed medically necessary for the patient to improve functional mobility. The purpose of Physical Therapy is to maximize your ability to perform daily activities required in work, leisure or sports activities by increasing strength, flexibility; and by managing pain.

We look forward to building a successful relationship with you that lasts a lifetime!

Signature_____ Date_____