



SPECHT

PHYSICAL THERAPY

Orthopedic & Sports Therapy Center

PATIENT REGISTRATION

NAME _____ DATE OF BIRTH _____ SSN# _____
FIRST MI LAST

ADDRESS _____
STREET CITY STATE ZIP

PHONE INFO: HOME _____ BEST # TO CONFIRM APPOINTMENTS

MOBILE _____ BEST # TO CONFIRM APPOINTMENTS

WORK _____ BEST # TO CONFIRM APPOINTMENTS

EMAIL ADDRESS _____

MALE FEMALE MARITAL STATUS: MARRIED SINGLE WIDOWED DIVORCED

IF YOU ARE A MINOR, GUARDIAN NAME _____ RELATION _____

EMERGENCY CONTACT:

NAME _____ PHONE _____ RELATION _____

EMPLOYMENT INFORMATION

EMPLOYED FULL-TIME PART-TIME RETIRED

LIGHT DUTY SINCE _____ OUT OF WORK SINCE _____

EMPLOYER _____

ADDRESS _____
STREET CITY STATE ZIP

HEALTH INSURANCE INFORMATION

PRIMARY _____ ID# _____ GROUP # _____

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION _____

PHONE # _____ SUBSCRIBER EMPLOYER _____

SECONDARY _____ ID# _____ GROUP # _____

SUBSCRIBER _____ DATE OF BIRTH _____ RELATION _____

PHONE # _____ SUBSCRIBER EMPLOYER _____

REFERRAL INFORMATION

REFERRING PHYSICIAN _____ PHONE # _____

ADDRESS _____
STREET CITY STATE ZIP

PRIMARY CARE PHYSICIAN _____ PHONE # _____

ADDRESS _____
STREET CITY STATE ZIP

HAVE YOU HAD PHYSICAL THERAPY FOR ANY PREVIOUS PROBLEMS? _____ IF YES, WHEN _____

PLEASE BE SURE TO COMPLETE THE OTHER SIDE OF THIS FORM →

AUTO INJURIES, WORK INJURIES and PERSONAL INJURIES ONLY – please complete the following section:

INJURY DATE _____ INJURY TYPE: WORK AUTO SLIP / FALL OTHER

IF WORK RELATED, DID YOU REPORT THIS TO YOUR EMPLOYER? YES NO CLAIM # _____

IF AN AUTO ACCIDENT, IN WHAT STATE DID THE ACCIDENT OCCUR? _____

HAVE YOU FILED A CLAIM FOR THIS INJURY YES NO CLAIM # _____

INSURANCE COMPANY _____ PHONE _____

ADDRESS _____ CONTACT PERSON _____

DO YOU HAVE AN ATTORNEY YES NO NAME _____

ADDRESS _____ PHONE _____

MISSED APPOINTMENT POLICY

ALL PATIENTS PLEASE READ

- Make every effort to attend all of your scheduled therapy sessions. This will speed your recovery process.
- If you are unable to attend an appointment, please let us know 24-hours in advance so we can offer your treatment time to another patient and get your appointment rescheduled to a more convenient time.
- There is a \$25.00 charge for missing an appointment without canceling.
- If you miss two or more appointments without canceling, we reserve the right to cancel all of your future appointments and require that you obtain a new referral from your physician to re-start treatment.

Initials _____

WORKERS COMPENSATION PATIENTS PLEASE READ

- Make every effort to attend all of your scheduled therapy sessions. This will speed your recovery process.
- If you are unable to attend an appointment, please let us know 24-hours in advance so we can offer your treatment time to another patient and get your appointment rescheduled to a more convenient time.
- If you miss two or more appointments without canceling, we will notify your physician, workers compensation insurance carrier and your employer that you are not attending your scheduled appointments. We also reserve the right to cancel all of your future appointments and require that you obtain a new referral from your physician to re-start treatment.

Initials _____

CONSENT TO TREAT

I, the undersigned, hereby voluntarily authorize Specht Physical Therapy to perform outpatient diagnostic evaluation and/or procedures and to administer such outpatient therapy that is necessary and appropriate. I understand that physical therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

AUTHORIZATION TO RELEASE INFORMATION

I, the undersigned, hereby authorize Specht Physical Therapy and the attending physician to release information relative to any outpatient therapy treatment administered to any third-party payor(s) financially responsible for these services or to my referring and/or primary care physician or therapist.

ACKNOWLEDGEMENT OF TERMS

By signing below, I attest that all information given is true and accurate to the best of my ability and that I have read and understand the policies stated above.

PATIENT SIGNATURE: _____ DATE _____

WITNESS SIGNATURE: _____ DATE _____



Financial Policy

YOU ARE RESPONSIBLE FOR:

Payment for all services rendered, by Specht Physical Therapy. Although we will do our part to submit claims to your insurance company, it is your responsibility to know your benefit and coverage limits. **If for any reason your insurance company fails to reimburse Specht Physical Therapy you will be responsible for payment for all services rendered.**

PRE-AUTHORIZATION AND REFERRALS:

It is your responsibility to know which services require pre-authorization. If your insurance plan requires a written referral from your Primary Care Physician (PCP) in order for Physical Therapy services to be initiated, you are required to provide this facility with the written referral prior to your first treatment.

INSURANCE PLANS WITH DEDUCTIBLES:

If you have an annual deductible, in which you must pay before your insurance company begins to cover services rendered, you will be responsible to make payment in full for all services rendered until your deductible has been met.

PLANS OF NON-PARTICIPATION:

We will provide the service of submitting claims to your Insurer if we are non-participating. However, if payment is not received within 90 days from the date of service, charges for services rendered to you or your family member become your responsibility. You are responsible for our entire charge less any payment from your insurer. If we do not participate with your secondary (or any non-primary) insurer, you are responsible for that portion of the bill at the time of service.

COVERAGE LIMITATIONS OF YOUR HEALTH INSURANCE PLAN:

Your health insurance plan provides payment for physical therapy services with the following limitations:

PAYMENT TERMS:

Payment is due at the time of service for insurance co-payments, annual deductibles and any services deemed non-covered by your insurance company. We accept Cash, Check, Money Orders, MasterCard, Visa, Discover and American Express.

Fees: Insufficient Fund Check Fee: \$25.00 Missed Appointment Fee: \$25.00

IN SIGNING THIS POLICY:

You assign your insurance benefits directly to Specht Physical Therapy. You authorize Specht Physical Therapy to release any medical information for claims reimbursement or clinical purposes. You certify that all information given by you is correct to the best of your knowledge. Your signature on this document serves as a "Signature On File" for all claims submitted to your insurance company for services rendered at Specht Physical Therapy.

PATIENT SIGNATURE _____ Date _____

GUARDIAN SIGNATURE
(If patient is a minor) _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Specht Physical Therapy.

Signature: _____ Date: _____

OFFICE USE ONLY

In lieu of patient signature, I, _____, a staff member of Specht Physical Therapy, state that _____ has been given our current Notice of Privacy Practices.

Signature: _____ Date: _____