

Catch A Wave Physical Therapy
DBA San Clemente Physical Therapy

Patient Registration Form— Shaded Areas, Office Only

Date: _____

| | | | | | | | | | | | |
|--|--|-----------------------------------|--|--|-----------------------------------|--|--|---|--|-------|--|
| Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/> | | | | Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/> | | | | | | | |
| <input type="checkbox"/> New Patient | | <input type="checkbox"/> Re-Start | | <input type="checkbox"/> New Diagnosis | | <input type="checkbox"/> New Insurance | | PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Patient # | | Title | Patient Name (Last, First, Middle Initial) | | | | | | | | |
| Address | | | | City/State/Zip | | | | | | | |
| Home Phone () | | | Work Phone () | | | Cell Phone () | | | | | |
| Social Security # | | DOB | | Gender <input type="checkbox"/> M <input type="checkbox"/> F | | Driver's License # | | Insurance Type <i>PPO, HMO, Medicare, etc</i> | | Email | |
| Referring Physician | | | Referring NPI (10 digits) | | Referring Physician Phone# () | | | Treating Therapist | | | |
| Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA | | Primary location CLINIC | | Marital Status | | Student Y <input type="checkbox"/> N <input type="checkbox"/> | | Employment Status | | | |
| Occupation | | | | Employer | | | | Employer Phone # | | | |
| Address | | | | City/State/Zip | | | | | | | |

Are you currently receiving healthcare service through a Home Health Agency (HHA)? Yes No

If yes, please provide name and phone number of the HHA. _____

| | | | | | | |
|--------------------------|--|-------------------|--|-------------------|-------------------------|--|
| Emergency Contact (Name) | | Home Phone () | | Work Phone () | | |
| Address | | City/State/Zip | | | Relationship to Patient | |

Financially Responsible Party Other than Patient

| | | | | | |
|------------------------------------|--|-------------------|---|---------------|--------------------|
| Name (First, Middle Initial, Last) | | | Relationship to Patient | | |
| Address | | | City/State/Zip | | |
| Home Phone () | | Work Phone () | | Email Address | |
| Social Security # | | DOB | Gender <input type="checkbox"/> M <input type="checkbox"/> F | | Driver's License # |

Injury Information

| | | | | | |
|---|--|---|-----------------------|--|--|
| Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date of Surgery | | Surgical Procedure | |
| Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date of Accident | |
| Describe Accident/Injury/Illness | | | | | |
| Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date of Injury | | Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No | |
| Name of employer at time of accident | | | City, State, Zip Code | | |
| Is litigation (lawsuit) involved? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Name of Attorney | | Phone # () | |

-Office Use Only-

| | | | | | |
|------------|--|--|-------------|--|--|
| Diagnosis: | | | ICD-9 Code: | | |
| Diagnosis: | | | ICD-9 Code: | | |
| Diagnosis: | | | ICD-9 Code: | | |

Office Policy Form

CONSENT FOR CARE & TREATMENT:

I do hereby consent to podiatric services at FACILITY. In so doing, I understand there are no guarantees to the result of treatment. I have been given the opportunity to ask questions and my questions have been answered to my satisfaction.

OFFICE POLICY ON PAYMENT:

It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made. A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. If a person knowingly violates that provision, the debt shall be void and unenforceable.

With in-network insurance coverage:

Your calculated **ESTIMATED** patient portion for each visit is \$_____ and \$_____ on the evaluation visit. This amount is based off of information gathered from your insurance company.

The amount stated above will be collected from you before each visit. All additional amounts owed as patient responsibility will be billed to you each month in an itemized patient statement.

With out-of-network insurance coverage:

Your **AGREED** patient portion \$_____ for your evaluation, \$_____ on _____ visits, then \$_____ for each visit after. As a courtesy we will bill your insurance to help you meet some of your out of pocket portions. The amounts stated are a discounted rate as our courtesy for paying at the time of service for all costs.

No insurance/private pay:

Your **AGREED** patient portion is \$_____ a visit and \$_____ for an evaluation and this amount will be collected from you at the time of service.

CANCELLATION/NO SHOW POLICY:

Our office requires 24 hr notice for cancelling an appointment. If we do not receive notice of cancellation within 24 hrs a \$25 cancellation/no show fee will be charged for that visit.

INSURANCE POLICY/ASSIGNMENT OF BENEFITS:

I request that payment of insurance benefits be made on my behalf to the provider for any services furnished to me. Insurance provides for your reimbursement on allowed medical charges. As a courtesy to you we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. **You are responsible for all deductibles and charges not covered by insurance.** Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:

I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

ELECTRONIC SUBMISSION OF MEDICAL INFORMATION:

I understand if I want a copy of my medical information or financial account history I will have the opportunity to provide my verbal authorization to receive that information via email at the time of the request. Email is not considered secure by HIPAA guidelines. My signature on this form indicates my understanding that by opening such an email, I gave verbal authorization to receive, I have also given written authorization. I am aware of any risk this may pose to my PHI.

MEDICARE

Home Health Warning (Medicare and Medicare Advantage Patients): Beneficiaries enrolled in a home health episode may not concurrently receive outpatient services, including physical therapy, as a Medicare covered benefit. Patients who have recently been discharged from an episode will not be eligible for paid outpatient services until Medicare's system recognizes the discharge. The undersigned agrees that he/she is aware of this policy and was educated by a staff member that any and all Medicare benefits denied or recouped for this reason will be patient responsibility.

I have read the above and accept financial responsibility in full for this account.

SIGNED: _____

Patient, Parent, or Guardian

DATE: _____