Elite Sports and Physical Therapy

PATIENT REGISTRATION

Today's Date _____ /_____ /_____ Auto Accident ___ Worker's Comp ____ Date of Injury ____ /_____ /_____

Name _____ Injury Area_____

Street Address _____ P.O.Box/Apt # _____

City_____ State_____ ZIP_____

Home Phone _____-_____-_____ Work Phone_____-_____-_____ Cell Phone_____-_____-_____

Male or Female Date of Birth ____/____/_____ E-Mail _____

How did you hear about Elite Physical Therapy? ☐ Referred by Doctor ☐ Referred by Friend ☐ Drive By ☐ Website

☐ Direct Mail ☐ Fitness Center Member ☐ Previous Patient ☐ Other:_____

Employer Information (Must complete for Worker's Comp Claims)

Employer _____

Address _____

Street City State Zip

Physician Information

Referring Physician Name _____

Primary Care Physician Name _____

Have you had physical therapy for this injury before? N Y When/where_____

Date you will return to your Doctor ____/_____/_____

MVA or Work Comp Claim Information

Claim Number_____ Insured Name _____

Insurance Company Name _____

Claims Adjuster _____ Phone _____

ATTORNEY: Name & telephone number _____

Primary Health Insurance Information

Insurance Name _____ Subscriber Name _____

Subscriber Birth Date ____/___/__ Patient relationship to subscriber _____

Subscriber Address _____

Street City State Zip

ID Number _____

Secondary Health Insurance Information

Insurance Name _____ Subscriber Name _____

Subscriber Birth Date ____/___/___ Patient relationship to subscriber _____

Subscriber Address _____

Street City State Zip

ID Number_____

CONSENT TO TREATMENT

I hereby authorize the professional staff at ***Elite Sports and Physical Therapy*** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I further consent to have my minor child treated by the staff of ***Elite Sports and Physical Therapy*** while I am not physically in the facility.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Parent / Guardian Name (Printed)	Parent / Guardian Signature	Relationship
_____	_____	
Witness	Date	

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

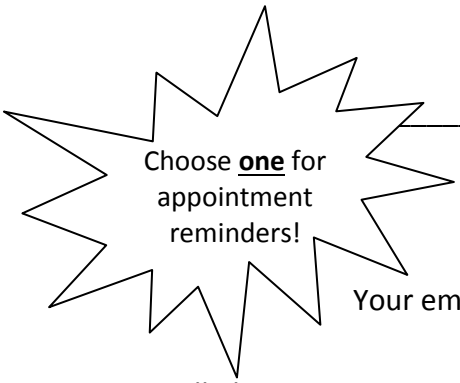
Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: ***Elite Sports and Physical Therapy*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that ***Elite Sports and Physical Therapy*** complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPAA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPAA guidelines.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Parent / Guardian Name (Printed)	Parent / Guardian Signature	Relationship
_____	_____	
Witness	Date	

Elite Sports and Physical Therapy



Please fill in below your preference in receiving appointment reminders.

Your email address _____

Cell Phone Carrier: **AT&T** **Verizon** **Sprint** **T Mobile** **Other**: _____

**Normal text messaging rates may apply.*

Emergency Contact Name _____

Emergency Contact Phone # _____

Relationship _____

CANCELLATION POLICY

Should you need to cancel your appointment please note that we require a

24-HOUR ADVANCED NOTICE

We will give you an appointment card to keep track of your appointments. If you should misplace this, please give us a call to review your appointment dates. We expect you to keep all your appointments; however we understand that there may be times when you cannot contact us and are unable to keep your appointment. If this happens please contact us at your earliest convenience to confirm your next appointment. Should you miss an appointment and not afford us the courtesy of a 24-hour advance notice so we can offer your appointment slot to another patient, **we reserve the right to charge you a fee.**

CANCELLATION FEE: $25.00; NO SHOW FEE: $40.00

If you miss three (3) consecutive appointments we will:
- Notify your physician and will require a new referral in order to continue your treatment
- At the discretion of the physical therapist, you may be discharged from therapy

_____ _____

Patient / Guardian Signature Date

Elite Sports and Physical Therapy

Elite Sports and Physical Therapy has contacted your health insurance company regarding your physical therapy benefits. We assume no liability for any errors made by your insurance carrier in this quotation. We will bill your health insurance carrier for services rendered as a courtesy to you and ask that you understand that the ultimate responsibility for payment is your responsibility. **We highly recommend that you call your insurance carrier to confirm your physical therapy benefits and responsibility.**

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance copayment, deductible, coinsurance or non-covered services
- Co-payments are due at time of service
- If my plan requires an insurance referral, I must obtain it prior to my visit
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service
- I am responsible to notify Elite Sports and Physical Therapy if my insurance coverage changes during the course of my treatment

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

- I hereby authorize and direct payment of my medical benefits to Elite Sports and Physical Therapy on my behalf for any services furnished to me by the Elite Sports and Physical Therapy
- If any payment is made directly to you by your health insurance company for services billed by us, please be aware that you must remit that payment to us. If not, we will bill you for the entire amount due for dates of services paid on.

Based on the benefit information provided to us on _____, your estimated responsibility is as follows:

Primary Insurance:

Co-pay _____/visit

Co-Insurance % to pay per visit _____/visit ☐ Authorization / Referral Required

Deductible _____/year/individual

Deductible _____/year/family Visit Limit _____

*All PT visits based on medical necessity

Secondary Insurance:

Co-pay _____/visit

Co-Insurance % to pay per visit _____/visit ☐ Authorization / Referral Required

Deductible _____/year/individual

Deductible _____/year/family Visit Limit _____

*All PT visits based on medical necessity

The above financial information has been read and explained to me. I UNDERSTAND MY FINANCIAL RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient / Guardian Signature Date

_____ _____

Witness Date

Elite Sports and Physical Therapy

CREDIT CARD POLICY / AUTHORIZATION

Beginning January 1, 2014, Elite Sports, Inc. (d/b/a Elite Sports Performance & Physical Therapy) will be requiring all patients to provide a valid credit card number to be kept on file in a secure and protected location until the conclusion of the patient's episode of care.

Please note that this credit card will only be billed in the event that a patient has any outstanding balances following the conclusion of treatment.

Cardholder's Name: _____

Cardholder's Billing Address: _____

City/Town: _____ **State:** _____ **Zip Code:** _____

Circle Type of Credit Card: **MC** **VISA** **DISCOVER** **AMEX**

☐ **Use Existing Stored Credit Card on File:** _____

Credit Card Number: _____

Expiration Date: _____

I hereby authorize Elite Sports, Inc. to keep my credit card information on file in order to pay any outstanding balances at the conclusion of my treatment. If I am sent a final statement detailing charges owed and I have not made other arrangements to pay the balance within ten (10) days of issue or have not disputed the bill, I grant permission for Elite Sports, Inc. to utilize the payment source provided above to pay off my account.

This form will be kept on file and will remain in effect until the conclusion of treatment and all outstanding balances are paid in full. Applicants must submit a written notification to Elite Sports, Inc. to revoke this form or report the credit card cancelled, lost or stolen.

_____ _____ _____

Patient / Guardian Printed Name | Patient / Guardian Signature | Date

_____ _____

Witness | Date