Patient Express Registration

Blessed Orthopedic Physical Therapy

Todays Date:

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

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

_____
Street Address City State ZIP

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

_____(_____)_____
Emergency Contact Person Phone # (if minor) Parent/Guardian Name and Signature

_____(_____)_____
Occupation Employer Name Phone #

● My condition is related to: ❑ Work ❑ Auto Accident (State_____) ❑ Other_____

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. Referral Info

ALL INFO REQUIRED

_____
How did you hear about us?

If by a friend or family member, please give their phone number and address below that we may send a thank you note and small gift.

_____

_____

_____
Primary or Referring Physician Name

_____
Street Address

_____
City State Zip

_____
Phone Fax

_____
Email Address

Do you have a followup appointment with this physician?_____

If yes, when? _____

3. Payment Info

(check only one box)

I am paying by **CASH, CHECK, CREDIT** and would like a . . .

- ❑ 30% discount by paying at the time of service.
- ❑ Payment plan. Fees may apply.

I have **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. The following infor mation is required prior to 1st visit.

  My coinsurance/copay is $_____

  My deductible is $_____

- ❑ Get a 30% discount by paying the entire bill at the time of service. I'll get reimbursement on my own. (Ask the front desk person for details)

I have an **ATTORNEY** and would like to . . .

- ❑ Get a 30% discount by paying up front. I'll get reimbursed after my case settles.
- ❑ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

4. Credit Card on File

Safe and Secure. I understand I will be notified of any and all charges prior to processing.

__Visa __MC __AmerX __Discover Card #_____

Name on Card_____ Exp Date_____ CVV code_____

❑ I have read and agree to all the policies on the back of this form. Signed_____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$10 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$10 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **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.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$10 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or 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 or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

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