

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 (Required in order to watch "New Patient Video") _____
 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 ___Temporary) Student (___P/T ___F/T)

2. My Condition

****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 \$ _____
 ___ Get a 20% 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)
- WORKERS COMP . . .**
 You must have all info provided under "My Condition..."
- CASH, CHECK, CREDIT** and would like a . . .
 ___ 20% discount by paying at the time of service.
 ___ Payment plan and apply for "Financial Hardship"
- I have an **ATTORNEY** and would like to . . .
 ___ Get a 20% 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. Referral Info

How did you hear about us?

- Friend or Family
- Internet
- Advertisement
- Brochure
- Insurance/Directory
- Other:

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

Referring Physician/Person's Name _____
 City _____ State _____
 Phone # _____

I have read and agree to all the policies on the back of this form. Signature _____

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 on the other side of this form (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 **\$30 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 \$30 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 **\$30 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 qualify for financial assistance according to 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 1128A(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 phone: 718-, by fax: 718-, by email: , by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, , Office of Counsel to the Inspector General, 718-

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

Informed Consent and Policies Agreement

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

- 1) Does your condition interfere with the quality of your life?
- 2) Does your condition interfere with your ability to perform work or daily activities?
- 3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
- 4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
- 5) Are there specific goals set that are measurable and track-able?
- 6) Is there a safety concern?

If the above criteria are not met, you are welcome to participate in our elective services such as MR4 Laser, massage, myofascial treatments, fitness/exercise training, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late

Please refer to the Express Registration Form.

Authorization for Release of Records

Assignment of Benefits (for insurance patients)

Please refer to the Assignment of Benefits form.

Results

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all

charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration

The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

Patient Signature/Date

Patient's Representative Signature/Date

Witness Signature/Date

Relationship to Patient

HIPAA Notice Acknowledgement & Consent

Restore Plus Physical Therapy & Rehabilitation

ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office **Restore Plus Physical Therapy & Rehabilitation** and understand my rights contained in the notice.

Signature of PATIENT or LEGAL GUARDIAN

Date

Print Name of Patient

Print Name of Legal Guardian, if applicable

CONSENT

I hereby give my consent for **Restore Plus Physical Therapy & Rehabilitation** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Restore Plus Physical Therapy & Rehabilitation** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Reginald Tiu, 3310 Queens Blvd. Suite 301, Long Island City, NY 11101**.

With this consent, **Restore Plus Physical Therapy & Rehabilitation** may:

- Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked "Personal and Confidential."
- Contact me by phone, mail, or email to participate in charitable events, patient appreciation days, educational seminars, health/wellness/fitness classes, or other marketing events to raise awareness, food donations, gifts, money, or promote pertinent products or services that might be useful to me.
- E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that **Restore Plus Physical Therapy & Rehabilitation** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Restore Plus Physical Therapy & Rehabilitation** to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Restore Plus Physical Therapy & Rehabilitation** may decline to provide treatment to me.

Signature of PATIENT or LEGAL GUARDIAN

Date

Print Name of Patient

Print Name of Legal Guardian, if applicable

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME: _____ AGE: _____ GENDER: Female Male

OCCUPATION: _____ ARE YOU WORKING NOW? Yes No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	<input type="checkbox"/> Yes (If yes, when and describe?) <input type="checkbox"/> No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all.....Mildly optimistic.....Fairly.....Very optimistic.....Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	Mild 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 Moderate Severe	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		

Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____