Atlantic Rehab Physical Therapy
Patient Registration Form

** Please be sure to fill out all forms **COMPLETELY** before returning to front desk **

Name: Last _____ First_____ MI_____
Address _____
City, State, Zip _____
Home Phone _____Cell Phone _____
Social Security Number _____
Date of Birth _____ Age: _____
Employed: FT PT R N/A Marital Status: M S D W Student: FT PT N/A
Referring Physician _____ Phone _____
Primary Care Physician _____ Phone _____
Email Address _____
Contact of Emergency _____Number_____

How did you hear about us? (Please check one) Doctor____ Insurance____ Self ____ Website____ Other_____

Have you had prior therapy? No Yes For which condition? _____
Is the problem related to a motor vehicle accident? No Yes
Is the problem related to a work injury? No Yes
Is the problem related to any other accident/injury? No Yes_____
Date of Onset/Injury/Accident _____

IF you answered yes to either of the above, please complete the following:
AUTO ACCIDENT/ WORKERS COMPENSATION INJURY **ONLY**
Place of Employment (WC) _____**Job Title**_____
Insurance Carrier: _____**Claim number:** _____
Claim Address _____
City, State, Zip _____
Adjuster: _____Phone number _____
Attorney Name _____
Phone number _____Fax number _____

REQUIRED HEALTH INSURANCE INFORMATION
Primary Insurance _____**Member number** _____
Who is the primary account holder? Self Spouse Parent Other _____
Secondary Insurance _____**Member number** _____
Who is the primary account holder? Self Spouse Parent Other _____

Information on Insurance Policy Holder (If other than self)
Name: Last _____ First_____ MI_____
Social Security Number _____ Date of Birth _____
Address _____ City/State/Zip _____

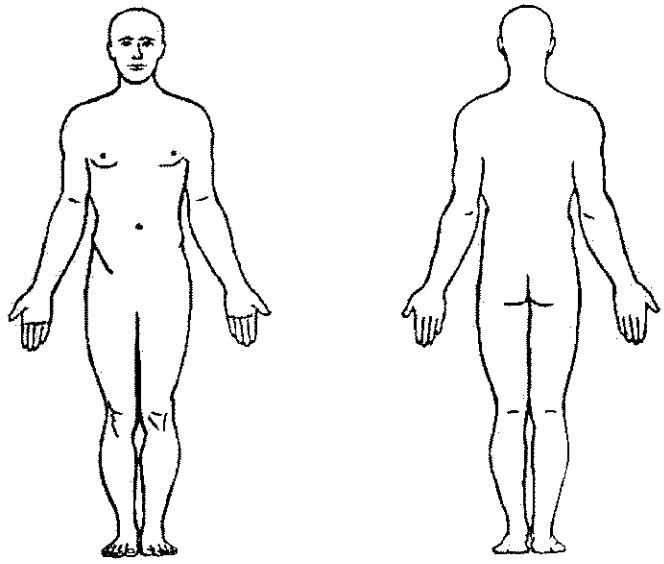
Circle if you have or have had the following:

AIDS	YES	NO
ALLERGIES	YES	NO
BREATHING PROBLEMS	YES	NO
CANCER	YES	NO
DENTAL PROBLEMS	YES	NO
DIABETES	YES	NO
DIZZINESS	YES	NO
HEADACHES	YES	NO
HEART TROUBLE	YES	NO
HEPATITIS	YES	NO
OSTEOPENIA	YES	NO
OSTEOPOROSIS	YES	NO
PACEMAKER	YES	NO
NUMBNESS	YES	NO
RECENT WEIGHT LOSS	YES	NO
RHEUMATOID ARTHRITIS	YES	NO
SEIZURES	YES	NO
STEROID USE	YES	NO
STROKE	YES	NO
SURGERIES	YES	NO
BACKACHES	YES	NO

Circle a number indicating your current pain level:

0 1 2 3 4 5 6 7 8 9 10

0= No Pain 10= Worse Possible



If you circled YES to any of the above questions please explain and give dates: _____

_____

_____

_____

Please mark the location of your pain on the drawing above and describe: _____

_____

_____

_____

List current medications and state the condition that they are for: _____

_____

_____

_____

_____

Allergic to any medications? Yes/No what kind? _____

_____

Check √ yes or not well for each question

	YES	NOT WELL		YES	NOT WELL
SITTING			STAIRS		
STANDING			DRESSING		
WALKING			PREPARING FOOD		
ROLLING			SQUATTING		
DRIVING			SHOPPING		
WALKING DISTANCE			LIFTING		
STOOPING			CARRYING		
RUNNING			REACHING		

Have you had X-rays, MRI, CAT scan, Bone Scan, etc. taken for this injury? Yes/No

Where_____ **When**_____

Are you sensitive to heat/cold? Yes/No

Atlantic Rehab Physical Therapy

OFFICE POLICIES

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do here by agree and give my consent for Atlantic Rehab, Inc to furnish medical care and treatment to **(print name here)** _____ considered necessary and proper in diagnosing or treating his/her condition.

Patient Signature: _____ **Date:** _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to which I am entitled, including private insurance and/or any other health plans to Atlantic Rehab, Inc. If my current policy prohibits direct payment to the provider, I hereby also instruct and direct my insurance company to make the check out to me and mail to: 5 Crain Hwy., suite 103 Glen Burnie, MD 21061. I authorize Atlantic Rehab, Inc to deposit checks received on patient's account when made out to the patient. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize Atlantic Rehab, Inc to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient Signature: _____ **Date:** _____

SCHEDULING AND CANCELLATION POLICY

Office Appointments are scheduled for your convenience, to minimize waiting and to enable you to incorporate these appointments into your schedule. Not showing up for scheduled appointments without prior notice is unfair to other patients who are waiting for appointments. Therefore, if you are unable to keep a scheduled appointment, we require 24 hour notice for canceling appointments. Failure to give notice will result in a $25.00 charge for missed office visits. This fee is due prior to your next visit.

Patient Signature: _____ **Date:** _____

FINANCIAL POLICY

1. All referrals, co-pays and balances owed on account must be given to the secretary when you sign in at the front desk for your appointment. Failure to provide a referral when your insurance requires one will result in rescheduling of your appointment. **Keeping your referral updated is the patient's responsibility.**
2. Returned checks will be assessed a ***$25.00*** cash fee.
3. Patient balances are payable within **30 days** of receipt of the bill. A **1.8%** monthly interest fee will be assessed for all outstanding balances. Balances that remain outstanding beyond 90 days unless payment arrangements are made will be sent to collections.
4. We accept VISA and MASTERCARD, CHECKS, MONEY ORDERS, AND CASH.
5. I understand, I am responsible for any balance not covered by or allowed by my insurance.

Patient Signature: _____ **Date:** _____

HIPPA POLICY ACKNOWLEDGEMENT

I have reviewed this practices' Notice of Privacy Practice written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual right, how I may exercise these rights, and the practices legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by this practice. A copy is available upon my request of the Notice of Privacy Practices for my records.

I, hereby acknowledge and understand receipt of the information regarding my obligations as a patient.

Patient Signature: _____ **Date:** _____

Relationship to patient (if signed by personal representative of patient) _____

ATLANTIC REHAB, INC
FINANCIAL POLICY/LIEN
*** EVERY PATIENT MUST SIGN ***

I do hereby authorize Atlantic Rehab, Inc to furnish my attorney/insurance carrier with a full medical report and itemized bill regarding services rendered to me for injuries incurred on the date of accident as I have indicated to you.

I further irrevocably assign to you, and authorized and direct my attorney (if applicable) to pay the proceeds of any settlement, judgment, or insurance policy, all fees for health care services rendered as a result of the injury or condition sustained on the date of accident. I understand that this in no way relieves me of my personal injury relationship to pay such services, and that the signing of this form does not prohibit customary billing by Atlantic Rehab, Inc. I further understand that my responsibility to Atlantic Rehab, Inc for payment is not contingent on any settlement, judgments or verdict.

I authorize Atlantic Rehab, Inc to bill my auto insurance and/or my private insurance as necessary. I authorize any insurance carrier to pay directly to Atlantic Rehab, Inc any sums which may be due and owing them as a result of Atlantic Rehab, Inc billing my insurance directly. If I directly receive any proceeds from any insurance, including personal injury protection and/or medical insurance, I agree to immediately make payment to Atlantic Rehab, Inc.

I will be responsible for any reimbursement to my private health insurance from my settlement (if applicable). I also understand that at that time, I am still fully responsible for any charges/bills resulting from or not covered by my medical insurance including, but not limited to: timely filing deadlines, referrals required, or any other reason why insurances may choose to deny payment of the claim. I also understand that if Atlantic Rehab, Inc is a non-participating provider, I will remain responsible for any unpaid balance due in full. I personally guarantee all amounts owed to Atlantic Rehab, Inc.

If a favorable settlement does not occur in the case of an accident, I will remain personally liable for payment of the bill for professional services rendered to me by Atlantic Rehab, Inc. In the event of non-payment, wherein my account is placed into collections, I agree to pay all collections costs, agency fees, court costs, and any other additional attorney/legal fees necessitated by any collection activity caused by my failure to clear any balance due.

I hereby waive the defense of stature of limitations in this state which is three years from the last date of service, or date monies were received on behalf of the patient. I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond three years after the date the last service was performed. I hereby agree that the statute of limitations, with respect to any claim for services mentioned above, will not begin to run until there is a denial in writing by me.

I further authorize my attorney, upon request, to notify Atlantic Rehab, Inc of any substantial change in status of the case including my updated personal information (current address, phone number, etc.).

ATLANTIC REHAB, INC
FINANCIAL POLICY/LIEN
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I authorized my attorney to notify Atlantic Rehab, Inc should their representation of my interests in connection with this accident be terminated for any reason.

I hereby give a lien to Atlantic Rehab, Inc on any settlement, claim, judgment, or verdict as a result of the accident, and authorize and direct my attorney to pay directly to Atlantic Rehab, Inc any monies which may be due and owing for service rendered. I authorize my attorney to withhold such sums from any settlement, claim, judgment, or verdict as may be necessary to protect Atlantic Rehab, Inc adequately.

I fully understand that I am directly and fully responsible to Atlantic Rehab, Inc for all bills submitted for services rendered to me, and that this agreement is made solely for additional protection and in consideration of this awaiting payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Date: _____

Patient name (please print): _____

Patient SSN: _____

Patient/Guardian Signature: _____

Attorney Please See Below (if applicable):

The undersigned, being attorney of record or authorized representative of insurance carrier for the above patient, does hereby acknowledge receipt of the above lien. The undersigned does agree to honor the same to protect Atlantic Rehab, Inc adequately. Please date, sign, fax back and keep a copy for your records. Thank you.

Date: _____

Authorized representative name (please print): _____

Authorized Signature: _____