New Patient Registration Form

Name: _____ Gender: _____ Date: _____

Birthdate: _____ Age: _____ Marital Status: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Primary Phone: _____ Emergency Contact: _____

Chief Complaint: _____ Date of Injury: _____ Date of Surgery: _____

Referring Dr: _____ Last Dr Appt: _____ Next Dr Appt: _____

Please list up to 5 medications; if more, please supply list:

_____

Please list any previous surgeries:

_____

Have you had any Diagnostic or Rehabilitative Services for this injury? MRI XRAYS OTHER

Do you have a history of any of the following conditions:

	YES	NO
COPD:	____	____
Stroke/TIA: Year:_____	____	____
Cancer: Location: _____ Year: _____	____	____
Blood Clots: ____ Pulm Emboli (lung ____ DVT (leg/arm)	____	____
Diabetes: Type: I _____ II _____	____	____

	YES	NO
Pacemaker:	____	____
Seizures:	____	____
Osteoarthritis:	____	____
High Blood Pressure:	____	____
Heart Disease: ____ Coronary Disease ____ Congestive Heart Failure ____ MI/Heart Attack Year:_____	____	____
Are you pregnant:	_____	_____
Tobacco Use:	_____	_____
Exercise Weekly:	_____	_____

Other Pertinent Medical Conditions_____

How did you hear about us:_____

PATIENT ACKNOWLEDGEMENT OF BILLING POLICIES & PROCEDURES

Welcome to Blue Ridge Physical Therapy. We are pleased that you have chosen this clinic for your therapy treatments. It is our desire to provide you with the best therapy in the most effective manner possible. To help keep our costs down, and yours, we have set a few guidelines.
PLEASE PRINT YOUR INITIALS NEXT TO EACH POLICY AND THEN SIGN BELOW

_____**Canceling Appointments:** We would appreciate at least 48 hour notice or more if you need to cancel your appointment. We understand that illness, family emergencies or bad weather are not planned and those things will cause last minute cancels. But there will be a $25.00 cancellation fee for those that have excessive cancellations/No Shows (3 or more within a reasonable time frame).

_____**Collections:** I agree and acknowledge that if my account should go to collections for any reason I will be financially responsible for all clinical charges and collection fees that Blue Ridge Physical Therapy would incur.

_____**Insurance Billing & Coverage:** Under your health plan, you are financially responsible for co-payments, co-insurance & deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract.
It is strongly advised that you check your insurance policy for your physical/occupational therapy benefits & items that may not be covered, as we are unable to know the exclusions of all of our patient's policies. *As a courtesy we check primary insurance benefits only before the evaluation for co-pays, deductibles & co-insurance amounts owed. As always, THIS IS NOT A GUARANTEE OF COVERAGE PER YOUR INSURANCE PROVIDERS.* Claims are reviewed, processed and paid as they are received by insurance.

_____**Privacy Practices:** We will only share your medical information with the health care provider that referred you here, your PCP and your insurance provider. If you request that we send this information to another healthcare provider or any other entity, we can do so if you sign off on a medical release form.

_____**Informed Consent for Treatment:** Physical and or occupational therapy treatment involves certain inherent risks. Patients are asked to exert effort and perform activities and exercises with increasing degrees of difficulty. The risks may include, but are not limited to cardiovascular, muscle, ligament, joint or disk injury. Symptomatic aggravation of your current condition is also possible. Risks have been reduced to the best of our ability; however, and increase in your current level of discomfort, or any other change in your symptoms should be immediately reported to a staff member.

I hereby agree and give consent to medical treatment for my physical condition. I authorize release of any medical information needed to process my claims. I understand that I am responsible for any charges that are not covered by my insurance carrier. I authorize release of payment directly to Blue Ridge Physical Therapy regardless of participation, in or out of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for all charges and collection costs incurred.

I have read, understand and agree to all of the above policies.

_____ _____ _____
Patient/Parent Signature Printed Name Date