New Patient Registration - Brunswick Physical Therapy, PLLC

Patient Name: _____ DOB: _____ M[ ] F[ ]
Social Security # (last 4 digits): __ __ __ __ [ ]Single [ ]Married [ ]Widowed [ ]Other
Address: _____ City: _____ State: ____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail Address: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Primary Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____
How did you hear about us? _____

Insurance Information

Insurance Company: _____
Member ID #: _____ Group #: _____
Secondary Insurance Company: _____
Member ID #: _____ Group #: _____
Subscriber Name (if different from patient): _____ DOB: _____
Address: _____ City: _____State: _____ Zip Code: _____
Subscriber's Relationship to Patient: _____

Worker's Comp or No Fault Accident Information

Type of Accident: [ ]Auto [ ]Work [ ]Home Date of Injury: ____ /___ /____
Insurance Name: _____ Contact Person Name: _____
Contact Person Phone:_____ Contact Person Fax:_____
Insurance Address: _____ Claim Number: _____
Employer Name: _____ Supervisor: _____ Phone: _____
Attorney Name (if applicable): _____
Full Social Security # required if Worker's Compensation: __ __ __ __ __ __ __ __ __

Assignment and Release

I , the undersigned certify that I (or my dependant) have insurance coverage with _____and assign directly to **Brunswick Physical Therapy PLLC** all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Physical Therapist/Brunswick Physical Therapy the use of this signature on all insurance submissions.

_____ _____
Signature of Patient/Responsible Party Date

_____
Printed Name

Name:			
Medications:			
Prior surgeries and date:			
Allergies and Reaction:			
Place an X if you have ever experienced or been told that you have any of the following?			
	X		X
Asthma		Chronic bronchitis	
Emphysema		Shortness of breath	
Chest pain		High blood pressure	
Heart disease		Blood clot	
Stroke		Head injury/concussion	
Dizziness		Fainting	
Epilepsy/seizures		Migraine/headaches	
Arthritis		Osteoporosis	
Gout		Cancer	
Diabetes		Visual loss	
Ear Infections		Hearing loss	
Fibromyalgia		Chemical dependency	
AIDS/HIV		Depression	
Kidney Disease		Anxiety	
Hepatitis/jaundice		Urinary Tract Infection	
Bowel/bladder problem		Thyroid problems	
Blood disorder		Anemia	
Pregnancy		Other:	
Have you had any medical diagnostic tests such as X-Ray, CT Scan, MRI, Ultrasound, Bone Scan, Blood Test, EMG or NCV, etc? Y/N			
Results of Tests:			

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information
Your protected health information will be used by Brunswick Physical Therapy or disclosed to others for the sole purpose of treatment or obtaining payment.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your protected health information.

Brunswick Physical Therapy may or may not agree to restrict the use or disclosure of your protected health information.

If Brunswick Physical Therapy agrees to your request, the restrictions will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected heath information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices
Brunswick Physical Therapy reserves the right to modify the privacy practices outlined in the notice. Patient will be notified prior to any modification.

Signature
I have reviewed this consent form and give my permission to Brunswick Physical Therapy to use and disclose my health information in accordance with it.

_____

Name printed

_____

Patient Signature

_____

Date

_____ _____

Signature of patient guardian/representative guardian/representative

Relationship of patient

Effective Date : This notice is in effect on or after June 1, 2009

Brunswick Physical Therapy
Office Policies and Procedures

Payment Policy

All copays are due at time of treatment.

Payment may be made by check, cash, or credit card (visa, Master card, or discover only)

A $20 service fee will be charged for checks returned for any reason.

Any bills submitted to the patient are payable upon receipt and will be subject to monthly interest charges if not paid within 30 days

Attendance

Your regular attendance is critical to your success. If you find it necessary to cancel an appointment for any reason, we require 24 hours notice.

No shows will be charged a $30 fee which is not covered under your insurance benefit.

I understand and agree to the office procedures outlined above.

_____ _____

Patient Signature/Responsible Party Date

Consults, Cancellations, No Shows