Scaccia Physical Therapy & Sports Conditioning, LLC

Patient Registration Form

GENERAL INFORMATION

Name:			Date of Birth:	
Address:		City:	State:	Zip Code:
Sex: M □ F □	Home Phone:	Cell Phone:	Email Address: Permission to receive emails from Scaccia PT & Affiliates: Y □ N □	
If Minor- Mom's Name:	Phone:	If Minor- Dad's Name:	Phone:	
Emergency Contact:		Relationship:	Phone:	

MEDICAL INFORMATION

Date of Injury :	Date of Surgery:	Diagnosis:	
Is your condition directly related to: Auto Accident □ Workers Comp □		**Have you had previous therapy/chiropractic for this condition? Y □ N □**	
Referring Physician:		Phone:	Fax:
Primary Care Physician:		Phone:	Fax:

PRIMARY INSURANCE INFORMATION

Insurance Carrier:	ID Number:
Group Number:	Insurance Phone:
Subscriber's Name:	Subscriber's DOB:
Relationship to patient:	Subscriber's Employer:

SECONDARY INSURANCE INFORMATION

Insurance Carrier:	ID Number:
Group Number:	Insurance Phone:
Subscriber's Name:	Subscriber's DOB:
Relationship to patient:	Subscriber's Employer:

WORKERS COMPENSATION/MOTOR VEHICLE ACCIDENT

Insurance Carrier:	Policy Holder:	Patient SS#:
Claim/Case#:	Case Manager/Contact:	Phone: Fax:
Patient's Employer:	Occupation:	Phone:
Date of Injury:	Attorney:	Phone: Fax:

Verifed: _____ Insurance Card □ Medical History □ Referral □ Prescription □ Copay Request □

Initial Evaluation scheduled for: _____ at _____ with _____

Scaccia Physical Therapy & Sports Conditioning, LLC

Patient Medical History Form

Name: _____ DOB: _____

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

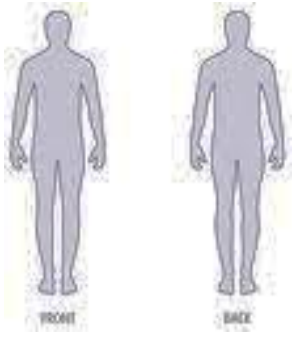
Patient Medical History: Please check all that apply

- ☐ Angina
- ☐ Heart Condition
- ☐ Pacemaker
- ☐ Circulation Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pulmonary Edema
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Diabetes
- ☐ Ulcers
- ☐ Dizzy Spells
- ☐ Fainting Spells
- ☐ Cancer
- ☐ Headaches
- ☐ Seizure Disorders
- ☐ Epilepsy
- ☐ Stroke
- ☐ Skin Disease
- ☐ Kidney Problems
- ☐ Back Pain or Problems
- ☐ Neck Pain or Problems
- ☐ Bowel or Bladder Problems
- ☐ Sensitivity to Heat/Cold
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis

Please circle the correct answer to following questions:

Do you have a history of fractures/breaks?	YES or NO	Where?_____
Do you have a history of back/neck pain?	YES or NO	When?_____
Do you have any metal implants?	YES or NO	Where?_____
Do you smoke?	YES or NO	How much?_____
Do you exercise regularly?	YES or NO	How often?_____
Do you have known drug allergies?	YES or NO	Please list_____
Females, Are you pregnant?	YES or NO	
Do you have any coordination or balance problems?	YES or NO	
Do you experience dizziness or vertigo?	YES or NO	
Have you experienced headaches as a result of your condition?	YES or NO	

*Please indicate on the diagram below where you experience pain/symptoms.



Please list all current medications:

_____

_____

Please list all surgeries/dates:

_____

_____

*Due to federal health care regulations, please provide height and weight below if you are insured through medicare. We are required to obtain this information.

Height: _____ Weight: _____

Signature:_____Date_____

***To my knowledge, the above information is correct:*

Scaccia Physical Therapy & Sports Conditioning, LLC

FINANCIAL RESPONSIBILITY, CONSENT TO TREAT, MEDICAL RECORDS

FINANCIAL RESPONSIBILITY POLICY

I hereby agree to pay my account as services are provided. If for any reason there is a balance on my account, I will pay promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through our billing department.

I hereby assign all physical therapy benefits to Scaccia Physical Therapy and Sports Conditioning, LLC. I understand that if my insurance benefits and/or eligibility are not approved by my health plan, then **I am financially responsible** and agree to pay for all charges related to services provided to the patient.

INSURANCE INFORMATION

- **IF THE PATIENT'S INSURANCE CARRIER REQUIRES A REFERRAL FOR THERAPY, IT IS THE PATIENT'S RESPONSIBILITY TO OBTAIN IT.**
- We will submit directly to your insurance carrier for payment. If you have a secondary insurance, please note it in the appropriate area and we will also bill them directly.

FINANCIAL INFORMATION

- Co-payments are due at the time of services. Deductibles are due upon receipt of the bill.
- Patient is responsible for a deposit of 50% when any equipment is special ordered.
- We will be happy to make payment arrangements if needed.

WORKER'S COMPENSATION

- We will bill the insurance carrier directly. All information must be obtained prior to the first visit. A personal insurance policy will be billed only if the worker's compensation claim is denied and documentation is provided.

MOTOR VEHICLE ACCIDENT

- We will bill the motor vehicle carrier directly. The patient is responsible if the carrier denies payment. An itemized bill will be provided for the patient to submit to the carrier for reimbursement.
- If no coverage exists, we will bill a health insurance policy only with written documentation of non-coverage or benefits exhaustion.

I certify that I have read and understand the above statements:

PATIENT SIGNATURE:_____Date:_____

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I hereby consent to the therapeutic procedures outlined below, to be performed by Scaccia Physical Therapy and Sports Conditioning, LLC.

- I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions &/or pain.
- I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilizations; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, E-stim and ultrasound.
- I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.
- I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I certify that I have read and understand the above consent statements:

PATIENT SIGNATURE:_____Date:_____

MEDICAL RECORDS

I hereby authorize Scaccia Physical Therapy and Sports Conditioning, LLC to release any and all medical records to my physician and/or insurance carrier. I also give permission for Scaccia Physical Therapy and Sports Conditioning, LLC to request records from my physician for the purpose of treatment. I recognize that the aforementioned records will be used in confidence. Please initial if you wish to be notified when records are transferred_____.

PATIENT SIGNATURE:_____Date:_____

Scaccia/Dracut Physical Therapy & Sports Conditioning, LLC

By signing below, I acknowledge and agree to the following:

Payment Requests/Referrals

All Insurance Co-payments, Co-insurance, and Deductible Payments Are Due At The Time Of Your Appointment

Your co-payment due at **EACH visit** is **$_____.**

Due to an increase in deductibles/co-insurances, we are requiring a payment of **$_____**at each visit to **reduce the amount of your final bill. PLEASE BE ADVISED THAT THERE WILL STILL BE A BALANCE DUE AT THE END OF YOUR TREATMENT.**

You are aware of your co-payment, co-insurance, and or deductible amount due to Scaccia/Dracut Physical Therapy and understand **YOU ARE RESPONSIBLE** for all payments towards the same. You understand and knowingly assume full responsibility for payment of any and all portions of your medical bills not covered by insurance. This includes, but is not limited to, insurance deductibles, co-payments and co-insurance charges.

You agree to pay any and all collection fees charged by or incurred by Scaccia/Dracut Physical Therapy. You further agree to pay all court and attorney fees incurred by Scaccia/Dracut Physical Therapy in their attempt to collect any outstanding bills/debts for services provided.

Please Note: You may not receive an immediate bill for charges due. It is your responsibility to review your patient responsibility statements from your insurance company to see what is due to Scaccia Physical Therapy.

Scaccia/Dracut Physical Therapy will verify your benefits as a courtesy. If there is a discrepancy between the benefits stated and your insurance policy, **the policy will override**. It is your responsibility to know your policy, obtain insurance referrals (if applicable) and to provide all the necessary information for Scaccia/Dracut Physical Therapy to bill the appropriate insurance company for services you are receiving.

If your insurance changes, you are responsible for notifying Scaccia/Dracut Physical Therapy immediately so that the proper referrals, authorizations, and billing changes may be completed.

Scaccia/Dracut Physical Therapy is not responsible for billing HSA/HRA accounts. It is your responsibility to keep track and make sure we are aware of any payments that we may receive from such accounts on your behalf.

Additional Comments:

_____

_____

Patient/Guardian Signature:_____ Date:_____

See Back for Cancellation/No-Show Policy Agreement

CANCELLATION/NO-SHOW POLICY:

In the event that you cannot attend a scheduled appointment, we ask that you call Scaccia/Dracut Physical Therapy **24 hours prior to the appointment to cancel and/or reschedule.** If you do not call to cancel and do not show up for a scheduled appointment, you will be charged **$50** for that missed appointment, due at your next scheduled appointment.

If you miss **3 scheduled appointments,** we reserve the right to discharge you from therapy or you will only be allowed to schedule appointments on the day of, when available. Extenuating circumstances will be considered at the discretion of the Therapists and/or Management.

Also, if you are more than **10 minutes late** for your appointment, it will be left to the discretion of your therapist whether or not you will be treated at that time.

If you have any questions about this policy, please do not hesitate to ask. Thank you in advance for your cooperation.

Contact: I give permission for Scaccia/Dracut Physical Therapy to contact me at home or at my work for any therapy/insurance related issue.

Notice of Privacy: I acknowledge that I have been given the opportunity to read Scaccia/Dracut Physical Therapy's Notice of Privacy Practices, and if I wish to obtain a copy, one shall be provided to me.

Payment Request Form: I acknowledge that I have read & understand my Payment Request Form, and if I wish to obtain a copy, one shall be provided to me.

_____	_____	_____
Signature of patient	Name of Patient (please print)	Date
_____	_____	_____
Parent/Guardian Signature	Name of Parent/Guardian	Date

Copy Given to Patient: _____