Patient Express Registration

Professional Rehabilitation Services

"The Outpatient Physical Therapy Specialists"

Today's Date_____/_____/ _____

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly

_____ _____ _____ ☐ Male ☐ Female

Last Name First Name MI

Social Security #_____Date of Birth_____/_____/_____Marital Status _____

_____

Street Address P.O. Box City State ZIP

(_____)_____(_____)_____

Home Phone Cell Phone **Email Address (Important)**

_____(_____)_____

Occupation Employer Name Phone #

Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled (_Total or_Temporary) ☐ Student (_P/T_F/T)

_____(_____)_____

Emergency Contact Person Phone # (if minor) Parent/Guardian Name and Signature

2. Referral Info

****All INFO REQUIRED***

How did you hear about us? (Check all that apply)

- ☐ Friend or family member (Name?) _____
- ☐ Website / Search Engine
- ☐ Insurance Website
- ☐ Other: _____
- ☐ Physician Referral:
  - (Name)_____
  - (Address)_____
  - (Phone #) _____

Do you have a follow up appointment with this physician?

If yes, when?_____/_____/_____

(A physical therapy report will be sent for your follow-up visit)

3. Appointment Reminders

I would like to receive my appointment reminders by:

- ☐ TEXT MESSAGE: Phone Number _____ -_____-_____
  Cell Phone Carrier? _____ ***Initial*** _____
- ☐ Email: _____ ***Initial*** _____
- ☐ I wish to only be notified by phone. ***Initial*** _____

By giving my phone or email address, I agree to receive appointment reminders and any business updates from PRS

4. Credit Card on File

Safe and Secure . This card will be used for any balance(s) on your account.

__Visa __MC CVV code(s) _____

Name on Card_____

Card #_____**Exp Date**___/___/___

There will be a nonrefundable $1.00 surcharge for credit card transactions

5. Payment Info

(Check one box and initial)

INSURANCE : I have insurance and would like you to….

☐_____Deal directly with my insurance company. Please submit all claims for billed services rendered. I will assign my benefits over to Professional Rehabilitation Services (must complete the "Assignment of Benefits" form). I understand that I am responsible for any deductible, co-payment or coinsurance associated with my insurance plan for each date of service. I also understand that my insurance plan may not cover all services received in Physical Therapy and that I am responsible for any non-covered expenses. **It is my responsibility to know my insurance coverage and any limitations on my policy.**

NO INSURANCE: I do not have insurance and I would like to…

☐_____Pay out-of-pocket with cash, check or credit card for services rendered at each date of service.

6. Consent

I have read and agree to all the polices on the back of this form. I hereby acknowledge that I have received a copy of the Professional Rehabilitation Services HIPAA Notice of Privacy Practices that states how PRS may use and/or disclose my health information.

See back of form

Signed_____**Dated:**_____/_____/_____

Important Company Policies for a Successful Relationship

Initial All Boxes 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 at the bottom of the front page.

☐ **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 overlaps because this undeservedly compromises the care of another patient.

☐ **Authorization for Treatment:**
I present myself or dependent for whom I am guardian for Physical Therapy procedures by direct access or, which are deemed medically necessary either by my referring physician, his assistants, or his designee and authorize any emergency medical care. I am aware that practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the results of examination and treatments by the facility.

☐ **Valuables**
PRS is not responsible for any valuables or other articles left on the premises, including the front desk or lobby.

☐ **Appointment Cancellation Fee**
If you wish to change or cancel an appointment, we require a minimum **24-hour advance notice**. Anything less will result in a ***$25 fee*** charged to your account including no-show appointments. Advanced notice allows our office time to contact another patient who needs our care to reserve this appointment time in place of you. Please be courteous and responsible. **It is your responsibility to pay this fee prior to your subsequent visit**. It is not covered by insurance or any 3rd party payor.

☐ **Treatment Plan**
To achieve maximum benefit from your physical therapy, it is imperative that you attend all your appointments each week recommended by the therapist and your physician. If you cancel or no-show for an appointment that visit needs to be made up during that week. If you do not attend consistently your treatment plan will not be effective and your insurance benefits and/or your worker's compensation may be affected or denied.

☐ **Co-pays / Deductible and Co-insurance (estimates) are due upon arrival at each visit (NO EXCEPTIONS)**
Payment is required at the time of service. If you have insurance you will be required to pay the estimated portion of your deductible, co-pay, co-insurance, and portions of charges your insurance does not pay at each visit. If you have no insurance, you will be required to pay the charges in full at each visit.

☐ **Late Fees / Collection Policy**
After thirty days of no payment on your billed statement from PRS a **$10.00** late fee will be added. If it becomes evident that you do not intend to take care of your financial obligation to PRS after 120 days your account will be forwarded to our collection agency. You agree to pay all collection fees of 35% added to the outstanding balance. If legal action is taken you agree to pay all attorneys, legal and court fees.

☐ **Accepted Payments for Services**
PRS accepts cash, checks, VISA & Mastercard only. **There will be a non-refundable $1.00 surcharge for all credit card payments.**

☐ **Return Check Fee**
A $30.00 fee will be charged for all returned checks, plus the amount of the returned check.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your co-pay, deductible or coinsurance payments . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Poverty Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan. 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 1128 A(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: (202) 619-1343, by fax: (202) 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, (202) 619-0089."

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