PATIENT REGISTRATION FORM

Midwest PHYSICAL THERAPY

Name: _____ ☐ **Male** ☐ **Female**

Last **First** **M.I.**

Address: _____

Street **City** **State** **Zip Code**

Home Phone: ( ) _____ **Cell Phone:** ( ) _____ **Email:** _____

Date of Birth: _____ **Social Security Number:** _____

Emergency Contact: _____ **Telephone #:** _____

Relationship: _____

If the patient is a minor:
Parent/Guardian Name: _____ Phone #:_____

Please List Current Medication: _____

_____

_____

_____

***INSURANCE INFORMATION*: (Please provide insurance card)**

Primary Insurance: _____ Policy ID#: _____
Policy holder: _____ Policy holder DOB: _____

Secondary Insurance: _____ Policy ID #: _____
Policy Holder: _____Policy Holder DOB: _____

Is this a worker's compensation claim? ☐ **YES** ☐ **NO** (***Private insurance information is still required)***
Employer: _____ **Date of Injury:** _____
Insurance: _____ **Claim #:**_____
Is an Attorney involved? Name: _____**Phone #:** _____

Is this an Automobile Accident claim? ☐ **YES** ☐ **NO** ***(Private insurance information is still required)***
Insurance: _____ **Claim#:** _____
Date of Accident: _____
Is an Attorney involved? Name: _____**Phone #:** _____

I verify that all of the above information is valid and completed to the best of my ability.

Signature: _____ **Date:** _____

(By Parent / Guardian if patient is under 18)

PATIENT AUTHORIZATION RECORD

CONSENT FOR TREATMENT

(Initial here)

•I hereby give my agreement and consent for Midwest Physical Therapy, Inc. to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

RELEASE OF INFORMATION

(Initial here)

• I agree that Midwest Physical Therapy, Inc. may provide information from my medical record to persons involved in my medical care.

• I authorize the release of medical information necessary to obtain payment of any benefits available to me to Midwest Physical Therapy, Inc. for services rendered.

•I agree that Midwest Physical Therapy, Inc. may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order treat, bill and/or receive payment.

•I have been offered a copy of the Notice of Privacy Practices mandated by HIPAA.

RELEASE OF PAYMENT

(Initial here)

•I authorize that direct payment of any benefits available to me be released to Midwest Physical Therapy, Inc. for services rendered.

PATIENT AGREEMENT

(Initial here)

•I agree to pay Midwest Physical Therapy, Inc. charges for services rendered to me during my course of treatment.

•I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Midwest Physical Therapy, Inc. collections costs including attorney and court fees.

CANCELLATION / NO SHOW POLICY

(Initial here)

•Due to the nature of physical, occupational and speech therapy, your progress and full recovery are dependent on both our therapists and your active participation and commitments to your appointments.

•If you need to cancel your appointment, please contact Midwest Physical Therapy, Inc. ***at least one day prior to your appointment.*** If you cancel your appointment on the same day as your appointment, **a $25.00 cancellation fee** will be assessed. The fee will be due at your next appointment. An appointment rescheduled for the same day or within the same week to meet the scheduled frequency , is not considered a cancellation. Midwest will waive **one** cancellation fee only. There will be no cancellation fee if schools in the local area are closed due to inclement weather.

•If you have a scheduled appointment and do not show, **a $25.00 No Show Fee will be assessed**. The fee will be due at your next scheduled appointment.

WORKERS COMPENSATION

(Initial here)

•I agree that the information given to Midwest Physical Therapy, Inc. in applying for benefits under Workers Compensation is complete and accurate. I agree that Midwest Physical Therapy, Inc. may give intermediary's information necessary to process claims.

Signature **Date**

Parent/Guardian Signature (if patient is a minor) **Date**