JAG-ONE PHYSICAL THERAPY

Registration Form

Patient Information:

First Name: ________________________________MI:______ Last Name: ____________________________

Address: ____

Apt: __________________ City: ________________________________ State:______ Zip Code:___________

Date of Birth: _________________ Age: _________ Gender: □ Male / □ Female / □ Other _________________

SS#: _________________________ Marital Status: □ Single /□ Married /□ Divorced /□ Other________________

Employer: _________________________Occupation: _______________________ Work #: ________________

Employer Address: ____

Preferred Contact:

□ Home: ___________________□ Cell Phone: _________________ □ Email: ____________________________

Appt. Reminders: □ Text / □ Email/ □ Voice call / □ None

Emergency Contact # ___________________________ Name/ Relationship ______________________________

Doctor Information:

Referring Physician: ____

Address: ____ ____

Phone Number: _______________________________ Fax Number: ____________________________________

Primary Physician: ___________________________________ Phone Number: ___________________________

Have you received Physical Therapy or Occupational Therapy treatment within the last 12 months? □ Yes / □ No

Have you attended any Chiropractic, Speech Therapy or Home Care? □ Yes / □ No

Insurance Information:

Primary Insurance Company: ____

Member ID# : _________________________________ Group ID# : ____________________________________

Is this the Patient's insurance? □ Yes / □ No If No who is the policy holder: ______________________________

Policy Holder DOB: ______________________ Relationship to patient: ____________________________________

Secondary Insurance Company: ____

Member ID# : _________________________________ Group ID# : ____________________________________

Is this the Patient's insurance? □ Yes / □ No If No who is the policy holder: ______________________________

Policy Holder DOB: ______________________ Relationship to patient: ____________________________________

** If you have a tertiary insurance please notify our office immediately.**

Accident Information: Auto (NF) or Workers Compensation (WC)

Is this work related? □ Yes / □ No - Auto Accident? □ Yes / □ No – Date of Accident/Injury: ___________________

Surgery: □ Yes / □ No -Date of surgery: ___________ What State did the accident occur in: _________________

Attorney Information: Name/Firm- ____

Attorney address: _______________________________________ Phone:_______________________________

NF/WC Insurance Carrier: ____

Claim Number:_____________________________________ Policy Number: ____________________________

Adjuster Name: ____________________________________ Phone Number: ____________________________

Adjuster Email: ____________________________________ Fax Number: _______________________________

Is your claim open? □ Yes / □ No Is your adjuster aware you are starting therapy? □ Yes / □ No

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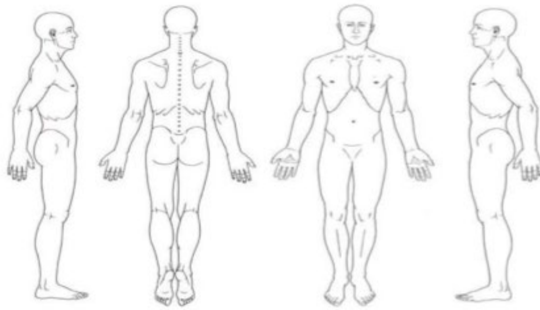
Medical History: Please indicate where you have pain or other symptoms



None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

□ Congenital Heart Defect
□ Heart Problems/ Heart Disease
□ Joint, Tendon or Muscular Pain
□ Osteoporosis
□ Pacemaker
□ High or Low Blood Pressure
□ Chest Pain/ Angina / Palpitations
□ Abdominal Pain/ Bloating/ Gas
□ Shortness of Breath
□ Coughing/ Wheezing or Exertion
□ Gout
□ Rheumatoid Arthritis
□ Anemia
□ Ulcers
□ Depression
□ Kidney Disease
□ Tuberculosis
□ Thyroid Problems
□ Asthma/ Bronchitis/ Pneumonia/ Chronic Cough
□ Stroke
□ Latex Allergy
□ Hepatitis A, B, C
□ Multiple Sclerosis
□ Other: ______________________________________

□ Cancer
□ Joint Replacement/ Repair
□ Gastrointestinal Issues
□ Skin Problems
□ Phycological
□ High or Low Blood Sugar
□ High Cholesterol
□ Emphysema
□ Poor Balance Recent Falls
□ Dizziness/ Vertigo/ Fainting/ Blackouts
□ Severe Headaches
□ Prostate Problems
□ Epilepsy/ Seizure Disorders
□ Circulation Problems/ Blood Clots
□ Liver Disease
□ Sexually Transmitted Disease/ HIV/ AIDS
□ Lung Disease
□ Allergies
□ Diabetes
□ Chemical Dependency (Alcoholism)
□ Lyme Disease
□ Painful Bowels/ Loose Stool/ Constipation
□ Depression/ Anxiety / Panic Attacks

Height: ____________________ Weight: ________________

Please provide details regarding the above checked conditions:

____
____

Medications: Please list all over the counter and prescription medications you are currently taking. Include dosage & frequency

____
____

Surgical History: List any surgical procedures you have had and the dates they were performed.

____
____

Diagnostic Testing: Please check any diagnostic testing and/or treatments you have completed for this condition:

□ MRI □ CT Scan □ X Ray □ Bone Scan □ EMG □ Cardiac Stress Test
□ Nerve Block □ Ultrasound □ Blood Tests □ Doppler Studies □ Injections □ Urinalysis

Other : ____

Patient Financial Responsibility Form

JAG-ONE Physical Therapy's focus is your overall health and wellness. As we continue to strive to help you meet these standards, it is important to us that you understand the terms **"Medically Necessary"**, **"Clinically Appropriate", "Benefit Maximum Met"** and how this relates to your treatment.

*"***Medically necessary***"* is defined as treatment or services that are specific to your diagnosis. When treatment is deemed medically necessary, your insurance company will reimburse JAG-ONE PT for services rendered according to physical therapy care that has a direct connection to document improved function based on our contractual agreement.

"**Clinically Appropriate**" or "**Benefit Maximum***":* Insurance companies may deny care despite treatment that continues to manage, reduce or eliminate your pain. This may be "clinically appropriate" for your circumstances but may not be considered "medically necessary" by your insurance carrier. Benefit Maximum is defined as a specific number of physical therapy visits allowed by your insurance policy during a specific time frame. Most treatments reach a point where no further improvement can be expected. This is called the point of maximum therapeutic benefit (MTB). MTB can be reached when complaints either fully resolve, or when pain and/or disability persist – even with ongoing treatment.

*"***Denials/Appeals**": It is a patient's responsibility to initiate an appeal with the insurance provider when services are denied.
JAG-ONE Physical Therapy will provide the necessary clinical information upon request.

If your insurance company determines that services are no longer medically necessary, you will be billed $100.00 per visit for services that have been rendered.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that JAG-ONE Physical Therapy may verify such coverage as a courtesy to me. JAG-ONE PT will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:

1. JAG-ONE Physical Therapy has discussed medical necessity limitations, clinically appropriate care, and specific number of office visits allowed per my insurance company.

2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary.

3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.

4. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

Patient Name: ____ **Date:**___________________________________

Patient Signature: ____

CONSENTS AND DISCLOSURES

(I) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

______ **INITIAL HERE TO GIVE CONSENT**: I am hereby giving my consent to JAG-ONE Physical Therapy office staff to discuss my medical condition or billing concerns with the person/persons I have designated below.

Name: ____Relationship:________________________

Name: ____Relationship:_________________________

Name: ____Relationship:________________________

______ **INITIAL HERE TO DECLINE CONSENT**

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, medical history and appointment reminder specifics (including date & time) will not be left on your answering machine, email and/or received in a text message; however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

______ **INITIAL HERE TO GIVE YOUR CONSENT:** I am hereby giving my consent for the JAG-ONE Physical Therapy office staff to leave medical history or appointment reminders (including date & time) on my telephone answering machine, email and/or text message.

______ **INITIAL HERE TO DECLINE CONSENT**

(III) PATIENT AUTHORIZATION TO TREAT AND SUBMIT MEDICAL CLAIMS

I authorize payment to JAG-ONE Physical Therapy, LLC for all physical therapy services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I consent to be assessed by and to receive treatment from JAG-ONE Physical Therapy, LLC consistent with a plan of care. I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by JAG-ONE Physical Therapy LLC and sign this consent willingly and voluntarily.

I consent to the release of information and/ or disclosure to JAG-ONE Physical Therapy, LLC of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I am aware my child is receiving Physical/Occupational Therapy at JAG-ONE Physical Therapy. I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

Parent/ Guardian initials if applicable: ___________________

I have read and fully understand the above Consents and Disclosures.

Patient Signature: ____ **Date:** ______________________

Parental Signature for Minor: ________________________________ **Date:** ______________________

ATTENTION

JAG-ONE Physical Therapy NO SHOW/CANCELLATION POLICY

As a courtesy to other patients, as well as the JAG-ONE Physical Therapy staff, we would appreciate a call of notification to cancel appointments at least 24 hours prior to your scheduled appointment. Please make sure to reschedule your appointment after cancelling. If a no call is received/documented your visit will be counted as a "NO SHOW."

In reference to missing or not showing to your scheduled appointment without prior notification, a fee of $35 will be collected upon your next visit. Hopefully, this policy will ensure better scheduling availability as to not block appointments for other patients. Should there be any misunderstandings or miscommunications regarding your scheduled appointment, please speak to our office manager.

REFERRALS

PLEASE CHECK IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICAN.

REFERRALS ARE PATIENT RESPONSIBILITY AND MUST BE COMPLETED AND TURNED IN TO JAG-ONE PHYSICAL THERAPY ONTIME TO AVOID ANY INSURANCE DENIALS.

Verification of Benefits

JAG-ONE Physical Therapy verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at JAG-ONE Physical Therapy.

We thank you in advance for your cooperation.

JAG-ONE PHYSICAL THERAPY