



## REGISTRATION FORM

### PATIENT INFORMATION

NAME:

FIRST

MI

LAST

ADDRESS:

NUMBER/STREET

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:

NUMBER/STREET

CITY

STATE

ZIP CODE

PREFERRED CONTACT:

HOME

CELL

EMAIL

APPOINTMENT REMINDERS:

TEXT

VOICE CALL

NONE

EMERGENCY CONTACT #:

NAME/RELATIONSHIP:

### DOCTOR INFORMATION

REFERRING PHYSICIAN:

ADDRESS:

NUMBER/STREET

CITY

STATE

ZIP CODE

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: \_\_\_\_\_

WHICH STATE DID THE ACCIDENT OCCUR IN: \_\_\_\_\_ Surgery?  YES  NO DATE OF SURGERY: \_\_\_\_\_

ATTORNEY INFORMATION: \_\_\_\_\_

NAME

FIRM

ATTORNEY ADDRESS: \_\_\_\_\_

NUMBER/STREET

CITY

STATE

ZIP CODE

NF/WC INSURANCE CARRIER: \_\_\_\_\_

CLAIM #: \_\_\_\_\_

POLICY #: \_\_\_\_\_

ADJUSTER NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

ADJUSTER EMAIL: \_\_\_\_\_

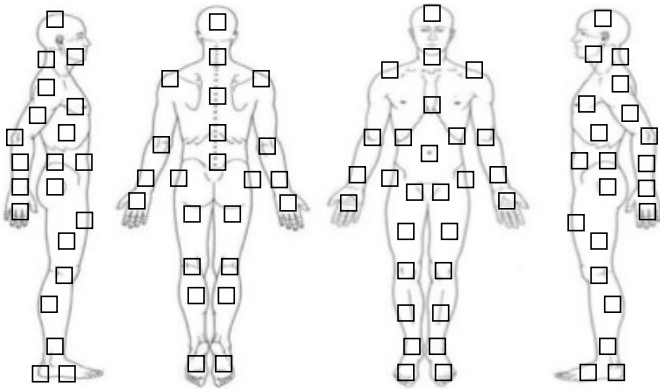
FAX NUMBER: \_\_\_\_\_

Is your claim open?  YES  NO

Is your adjuster aware you are starting therapy?  YES  NO

## MEDICAL HISTORY

Please indicate where you have pain or other symptoms



None \_\_\_\_\_ → Unbearable  
 0  1  2  3  4  5  6  7  8  9  10

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

### MEDICATIONS:

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

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### SURGICAL HISTORY:

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

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### DIAGNOSTIC TESTING:

Please check any diagnostic testing and/or treatments you have completed for this condition.

<input type="checkbox"/> MRI	<input type="checkbox"/> CT Scan
<input type="checkbox"/> Nerve Block	<input type="checkbox"/> Ultrasound
<input type="checkbox"/> X Ray	<input type="checkbox"/> Bone Scan
<input type="checkbox"/> Blood Tests	<input type="checkbox"/> Doppler Studies
<input type="checkbox"/> EMG	<input type="checkbox"/> Cardiac Stress Test
<input type="checkbox"/> Injections	<input type="checkbox"/> Urinalysis
<input type="checkbox"/> Other: _____	

- Congenital Heart Defect
- Cancer
- Heart Problems/Heart Disease
- Joint Replacement/Repair
- Joint, Tendon or Muscular Pain
- Gastrointestinal Issues
- Osteoporosis
- Skin Problems
- Pacemaker
- Psychological
- High or Low Blood Pressure
- High or Low Blood Sugar
- Chest Pain/Angina/Palpitations
- High Cholesterol
- Abdominal Pain/Bloating/Gas
- Emphysema
- Shortness of Breath
- Poor Balance Recent Falls
- Coughing/Wheezing or Exertion
- Dizziness/Vertigo/Fainting/Blackouts
- Gout
- Severe Headaches
- Rheumatoid Arthritis
- Prostate Problems
- Anemia
- Epilepsy/Seizure Disorders
- Ulcers
- Circulation Problems/ Blood Clots
- Depression
- Liver Disease
- Kidney Disease
- Sexually Transmitted Disease/HIV/AIDS
- Tuberculosis
- Lung Disease
- Thyroid Problems
- Allergies
- Asthma/Bronchitis/Pneumonia/Chronic Cough
- Diabetes
- Stroke
- Chemical Dependency (Alcoholism)
- Latex Allergy
- Lyme Disease
- Hepatitis A, B, C
- Painful Bowels/Loose Stool/Constipation
- Multiple Sclerosis
- Depression/Anxiety/Panic Attacks
- Other: \_\_\_\_\_

Please provide details regarding the above checked conditions:

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## PATIENT FINANCIAL RESPONSIBILITY

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: \_\_\_\_\_

**(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 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 canceling. If a no call is received/documentated 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 PHYSICIAN.

REFERRALS ARE PATIENT RESPONSIBILITY AND MUST BE COMPLETED AND TURNED IN TO JAG-ONE PHYSICAL THERAPY ON TIME 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.**

## PATIENT BILL OF RIGHTS

JAG-ONE Physical Therapy strives to ensure that each patient is provided the highest quality of care in accordance with high professional standards that are continually maintained and reviewed. We understand that patients have entrusted their care to us and we treat all patients with dignity, respect, and only provide appropriate services as needed. By requiring informed consent for treatment, we assure that each patient and/or his/her representative is involved in aspects of a treatment plan. Patients and their representatives are afforded consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discretely. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. We will endeavor to involve patients in their treatment program by incorporating their feeling, interest, attitudes and goals in the treatment planning and implementation process. A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.

**I HAVE READ AND FULLY UNDERSTAND THE ABOVE PATIENT BILL OF RIGHTS.**

PATIENT SIGNATURE:

DATE:

PARENTAL SIGNATURE FOR MINOR:

DATE: