PATIENT REGISTRATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent if Patient is a Minor				
Patient's Social Security Number				
Home Address	City	State	Zip	
Mailing Address (if different than above)	City	State	Zip	
Home Phone	Work Phone		Cell Phone	
Occupation		E-Mail Address		
Employer	Address	City	State	Zip
Spouse Name		Employer		
Primary Care Physician's Name				
Whom May We Thank for Referring You to Our Practice?				
NOTIFY IN CASE OF EMERGENCY				
Name		Relationship		
Address	City	State	Zip	
Home Telephone		Work Telephone		
Nearest Relative (not living with your)				
Home Telephone		Work Telephone		
INSURANCE POLICY HOLDER INFORMATION				
Name		Telephone		
Address	City	State	Zip	
Insurance Company		Claim Address		
Subscriber's Name		**Subscriber's Date of Birth**		
Insurance ID No.:		**Group #:**		
Were You Injured on the Job? YES NO		Have you Informed Your Employer? YES NO		
Date of Original Injury:				
Worker's Compensation Carrier Name		Address		

What problem brings you to see us today? _____

_____

_____

When did this problem start: _____

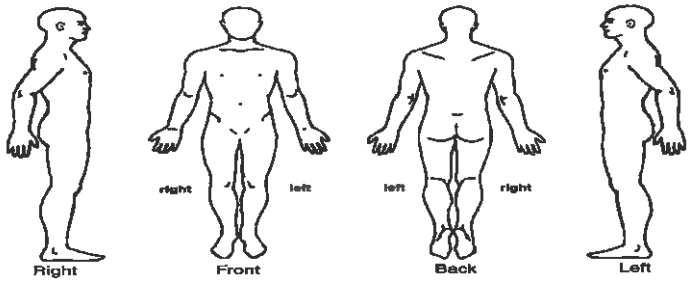
Did it come on: __ *Suddenly* __ *Built up over time* __ *Gradually worse over a long time*

If you were injured, was it: __ *At Work* __ *At Home* __ *Due to an Auto Accident*

On the figures at the right, Please mark your area(s) of pain or discomfort.

+++ Burning /// Stabbing

..... Pins & Needles xxx No feelings



Circle the areas (if more than one) of pain and tell us on a scale of 1-10, with 1 being light pain to 10 being very severe, how severe is your pain...

Area 1 pain is (1 - 10) ___ Constant or Intermittent

Area 2 pain is (1-10) ___ Constant or Intermittent

Please help us understand your pain:

Area 1 is: *Worse in AM* *At night* *After exertion* **It is:** *Sharp* *Stabbing* *Dull* *Achy* *Throbbing* *Burning* *Tingling*

Area 2 is: *Worse in AM* *At night* *After exertion* **It is:** *Sharp* *Stabbing* *Dull* *Achy* *Throbbing* *Burning* *Tingling*

I have difficulty with: *Walking* *Sitting* *Standing* *Driving a car* *Sleeping* *My daily routine* *Bladder control* *Depression*

I currently am: *Ambulatory without assistance* **Need to use:** *Support brace* _____ *Walker* *Cane* *Crutches* *Wheelchair*

Please help us better understand your personal circumstances:

I Am __ *Working* __ *Full Time* __ *Part Time* __ *Homemaker* __ *Full Time Student* __ *Unemployed* __ *Retired*

Occupation: _____ __ *On sick leave* __ *On temporary disability* __ *On full disability*

I now __ *Smoke* __ *packs per day* __ *Stopped* _____ __ *Consume Caffeine (Type/Amount)* _____

__ *Use Alcohol (Type/Amount)* _____ __ *Use recreational drugs* _____

I am now or have in the past been: __ *Addicted to: Drugs / Alcohol* __ *Treated for: Alcohol / Drug Addiction*

Women Only: Are you now or could you become pregnant? YES NO

Patient Signature: _____ Date: _____

If you previously had any of the following procedures, please list the date and place they were performed:

Procedure:	*Date:*	*Place Performed:*
X-Rays / CT / MRI	_____	_____
Myelogram	_____	_____
EMG	_____	_____

Please mark any conditions that you now have of have recovered from in the recent past:

__ *Severe Headaches*	__*Gout*	__*Pancreatitis*	__*Liver Disease*	__ *Digestive Problems*
__ *Hypertension*	__*Diabetes*	__*Arthritis*	__ *Epilepsy*	__*Renal Disease*
__*Heart Condition*	__ *Stroke*	__ *Arrhythmia*	__ *HIV/AIDS*	__*Endocrine Disease*
__ *Fatigue*	__*Dizziness*	__ *Fainting*	__ *Anemia*	__ *Prostate Problem*
__*Ulcers*	__*Asthma*	__*Gout*	__ *Gall Stones*	

Please list all surgery and any periods of hospitalization:

_____ _____

_____ _____

Current Medications: (Please list all medications you are currently taking):

Name of Medication:	*Dosage/Day*	*Name of Medication:*	*Dosage/Day*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History:

Condition	*Who?*	*Condition*	*Who?*
__ Heart Disease	_____	__ Epilepsy	_____
__ Hypertension	_____	__ Glaucoma	_____
__ Stroke	_____	__ Bleeding Disorders	_____
__ Caner	_____	__ Kidney Disease	_____
__ Diabetes	_____	__ Thyroid Disease	_____

Do you require special care or have any concerns that might affect your treatment or recovery? Y or N

If yes, please describe: _____

Patient Signature: _____ **Date:** _____

FEE EXPLANATION

Dear Patient:

Your fee for service includes your visit with the doctor based on the time and complexity of your condition and any treatment provided. In addition, proper attention to your case requires that the doctor spend more time working for you outside your direct visit with him or her. Such time may include:

- Creation of a permanent medical record.
- Review of all laboratory blood test results (e.g., a biochemical survey and CBC contain 42 separate tests to interpret and file in your chart).
- Review of prior and current x-ray or scan reports and personal review with the radiologist of abnormal studies.
- Preparation and mailing of consultation reports and follow-up visits letters and laboratory/scan results to referring physicians and any subsequent consulting.
- Follow-up phone call or letter regarding laboratory test results of patients and/or copies of test results when indicated or requested.
- Phone consultation with referring or consulting physicians and other health care providers about your case.
- Other phone calls to and from you and your family members for various reasons.
- Referral letters to any further specialists recommended by the doctor.
- Patient educational materials and medication samples when available.
- Any research done by the doctor about your case. The doctor used medical libraries and computerized medical search services.
- Staff assistance regarding your visit.
- Arranging and coordinating other tests and consultations.
- Calls to and from pharmacies.
- Insurance application forms: health insurance, disability insurance, life insurance.
- Insurance reports: health claims, disability claims to insurance and state, Medicare disability.
- Discussions (sometimes acrimonious) with hospitalization utilization review, insurance companies, or Medicare for ongoing hospitalization.
- Review and management of hospital records.
- Letters of necessity to obtain medical instruments or prescriptions.
- Letters of necessity for medical services to insurance companies.
- Arrangements for hospitalization with hospital admissions, house staff physicians and consulting physicians, and test/treating facilities.
- Communication daily during admission with nurses, house staff, and attending physicians.
- Tumor registry and other required reports.
- Home health care and nursing facility orders.
- Other reports and forms: jury duty, school, job, sick leave, back to work, communicable disease, etc.

In addition, the doctor participates extensively in continuing medical education, clinical research, teaching, and medical writing to keep up-to-date on the latest medical advances.

At our office, we feel a strong commitment to keep costs to our patients down. Even so, the cost of salaries, rent, taxes, insurance, billing, postage, photocopying, medical supplies, office supplies, medical journals and textbooks, and other materials keeps increasing. We charge only what we feel is necessary in order to maintain the highest standard of care. We look forward to a lasting and healthy relationship with you.

Sincerely,

Office of Administration
Advanced Physical Medicine

Financial Policy and Statement

If You Do Not Have Insurance: All payments are expected at the time of service or by a mutually agreeable payment plan.

If You Have Insurance: All deductibles and co-payments are expected at the time of service or by a mutually agreeable payment plan.

Your personal balance may not exceed $100 at anytime or care may be suspended. Our financial care plans make care affordable, and we will visit with you regarding these plans.

You are considered a cash patient until you bring in your completed insurance information, and we qualify and accept your insurance coverage. If during your course of care, your insurance coverage is terminated or interrupted, you will be considered a cash case and services are expected to be paid for at the time of service with a 20% administrative reduction due to not having to submit and follow up with your insurance. Should any of the services that were paid for as a cash case be reprocessed by your insurance company due to termination in error, any payments made by you will be refunded once your claims have been processed.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim in which our billing office will notify you of this need, and will help you navigate the process. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card, debit card, or ACH bank withdrawal information on file to collect payment in full.

If you discontinue care for any reason other than discharge by your provider, all outstanding balances will become immediately due and payable in full by you.

If a payment is returned by your bank or creditor unpaid for any reason, we reserve the right to charge the fees to you, along with an additional fee of $30.00. Any and all financial information provided by you will be protected as part of your Personal Health Information and additionally protected under federal HIPAA regulation and therefore subject to a $10,000 fine to anyone who misuses this information.

*****If you have an outstanding balance, are no longer receiving care in our office and there has been no attempt, by you, to communicate with our office to rectify your balance, your account will be turned over to collections after 30 days.*****

Signature:_____ **Date:**_____

FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

BASIC POLICY Payment for service is due in full at the time service is provided in our office.

FOR PATIENTS WITH INSURANCE We will bill your primary insurance company. We ***DO NOT*** bill secondary insurance companies. ***Copayments are due at the time of service.*** Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

MEDICARE PATIENTS We will bill Medicare for you. Medicare will crossover claims to secondary insurance for you. If you do not have a secondary insurance, you will be responsible for the amount not covered by Medicare.

MEDICAID PATIENTS We DO NOT accept Medicaid. All fees of services rendered will be due at time of service.

NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES We will bill your medical payment portion of your personal auto insurance or your major medical insurance carrier for services related to your personal injury case. If third party insurance is being billed, we will submit a lien for payment upon settlement of the case.

WORKER'S COMPENSATION If your injury is work-related, we will need the case number, carrier name and contact information prior to your visits in order to bill the worker's compensation insurance company.

MISSED APPOINTMENTS In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged $25 for missed appointments. Missed appointments occuring on a Saturday **will be** charged a $25 cancellation fee.

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Physical Medicine & Rehab for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurances please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to APM&R. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees.
THE PATIENT IS ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL FEES.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our privacy practices brochure is located at our front desk and is available to all patients.

I, _____, have received a copy of this office's Notice of Privacy Practices.

X_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, acknowledgement could not be obtained because:

___ *Individual refused to sign*

___ *Communication barriers prohibited obtaining the acknowledgement*

___ *Other (Please specify)* _____

HIPAA COMPLIANCE

In order to keep our office running efficiently, please sign this waiver allowing us to keep a daily record of your appointments. This will keep us up to date with current HIPAA regulations.

X _____ _____

Signature Date