BONITA SPRINGS SPORTS &
PHYSICAL THERAPY CENTER, INC.

REGISTRATION FORM
PLEASE PRINT

FIRST: LAST: INITIAL:

LOCAL ADDRESS: e-mail

CITY: STATE: ZIP:

PHONE: 2nd #: CELL:

DATE OF BIRTH: SEX: MALE / FEMALE

SOCIAL SECURITY #: MARITAL STATUS: M / W / S / D

EMERGENCY CONTACT: PHONE:

NORTHERN ADDRESS: PHONE:

CITY: STATE: ZIP:

DOCTORS NAME: Dr. PHONE #:

DATE OF SURGERY:

HAVE YOU HAD ANY PHYSICAL THERAPY SOMEWHERE ELSE THIS YES / NO

HAVE YOU HAD ANY HOME HEALTH THIS YEAR? YES / NO

IF YES, WHEN WERE YOU DISCHARGED?

HOME HEALTH COMPANY :

UNFORTUNATELY, WE ARE NO LONGER ABLE TO ACCEPT "AUTO INSURANCE CLAIMS" (2014 PIP La

IS THIS VISIT RELATED TO A MOTOR VEHICLE ACCIDENT? YES / NO

CURRENT MEDICATION LIST

Please provide a COMPLETE list of all medications you are currently taking. This includes all prescription drugs, over-the-counter medications, nutritional or dietary supplements, etc.

THANK YOU!!

NAME: _____

DATE OF BIRTH: _____

DRUG NAME	DOSAGE	FREQUENCY	ROUTE (Oral, Inject, Patch,	REASON YOU TAKE THIS DRUG

AUTHORIZATION FOR PHYSICAL THERAPY TREATMENT

- I consent and authorize to receive physical therapy services under the direction of a Licensed Physical Therapist.

- Unless treatment would require isolation, I authorize the physical therapy services to be provided in areas not totally isolated from other patients or personnel.

- HIPPA COMPLIANCE - I have received the HIPAA Notice of Privacy Practices (NPP) and with my signature below acknowledge such receipt. The NPP has also been made readily available to me at any time. I understand that Bonita Springs Sports & Physical Therapy Center, Inc. is in full compliance according to all HIPAA Rules and Regulations effective September 23, 2013 (Omnibus Final Rule and HITECH Act issued by the Department of Health and Human Services (HHS). I understand that every measure will be taken to protect my Personal Health Information (PHI) and I authorize release of minimum necessary information of medical records to those allowable by law.

PAYMENT POLICY, AUTHORIZATION & ASSIGNMENT

- I hereby directly assign my rights and benefits under my insurance policy to Provider (Bonita Springs Sports & Physical Therapy Center, Inc.) all medical insurance benefits (primary and secondary, including med.gap providers) or other benefits to which I, the patient, may be entitled for all physical therapy services rendered to me by the Provider.

- I request that payment of authorized insurance benefits be made on my behalf directly to Bonita Springs Sports & Physical Therapy Center, Inc. (Owner: Dr. Sandra L. Klassen, M.S., D.P.T., A.T., C.). If my current policy prohibits direct payment to the Provider, I will direct payment, endorsing the check I receive, to Provider. Direct mailing address is as follows: Bonita Springs Sports & Physical Therapy Center, Inc., 26201 S. Tamiami Trail, Bonita Springs, Florida 34134. This payment will be for the medical expenses/benefits allowable and otherwise payable to Provider under my current insurance policy as payment toward the total charges for the professional services rendered.

- I understand that my insurance policy is a contract between my insurance company and me and that Bonita Springs Sports & Physical Therapy Center, Inc. is filing claims on my behalf as a service to me. I agree that I will be financially responsible for any portion of Provider's invoice that is not paid, including but not limited to (i) any applicable deductibles or co-insurance or co-pays, (ii) any non-insured or non-covered services authorized, or (iii) any charges in excess of payment limitations imposed by third party payers as allowable by contract. Patient authorizes Provider to represent patient during the appeals process in the event of a denial of medical benefits.

- Any outstanding balance after insurance payments will be due within 14 days of notice. If assistance for financial arrangements is needed, you may speak with the billing manager.

- Patients are liable for all charges not covered by insurance companies either primary or secondary policies; this includes Medicare's deductible, Secondary insurance deductible and any & all co-payments and / or co-insurances. In most instances it is a felony to waive or tamper with a deductible or co-payment/co-insurance. These payments are your responsibility because of the contract made between you & your insurance carrier.

- If your account is 90 days past due from billing date and the account needs to be sent to collections, small claims court or attorney, you will be responsible for court cost, attorney's fees and all costs pertaining to collections. Returned checks will be charged a $25.00 service fee.

- A photocopy of this assignment shall be considered as effective and valid as the original.

- I authorize the physical therapist to initiate a complaint to the insurance commissioner for any reason on my behalf.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

BONITA SPRINGS SPORTS & PHYSICAL THERAPY CENTER, INC.

HIPAA COMPLIANCE

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by a medical provider (including physical therapist), in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used.

HIPAA Rules and Regulations have been updated and revised, effective September 23, 2013 (The Omnibus Final Rule and HITECH Act issued by the Department of Health and Human Services (HHS). As required by law Bonita Springs Sports & Physical Therapy Center, Inc. is in full compliance according to all HIPAA Rules & Regulations.

Bonita Springs Sports & Physical Therapy Center, Inc. will do everything in our power to protect your health information!

Bonita Springs Sports & Physical Therapy Center, Inc. is required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. As such, with my signature below I acknowledge that I have received the HIPPA Notice of Privacy Practices (NPP). Bonita Springs Sports & Physical Therapy Center, Inc. has also made the NPP readily available to me at any time.

I authorize the release of minimum necessary information of medical records to my referring physician, insurance company, adjuster and/or attorney involved in my case. I authorize the release of minimum necessary information of medical records as restricted by HIPAA Rules and Regulations for treatment, payment and health care operations.

I authorize the following to discuss questions about my medical billing account. With my signature below, I give permission for my billing questions / accounts to be discussed with:

_____ _____.
(Name) (Relationship)

_____ _____.
(Name) (Relationship)

_____ _____.
(Name) (Relationship)

This notice is effective and compliant to all revised Omnibus Final Rule effective September 23, 2013.

PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____