Pro-Active Physical Therapy ❑Benton Physical Therapy
❑Pro-Active PT- Bryant
Registration Form ❑Malvern Physical Therapy

(Please Print)

Today's date:			Referring Physician:				
PATIENT INFORMATION							
Patient's last name: First: M. I.:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is injury due to auto accident? ❑ Yes ❑ No	E-mail address:		Birth date: / /		Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Primary phone no.: ( )			
P.O. box:	City:		State:	ZIP Code:			
Occupation:	Employer:		Employer phone no.: ( )				
Chose clinic because/Referred to clinic by (please check one box):	❑ Dr.		❑ Insurance Plan		❑ Hospital		
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other			
Other family members seen here:							

INSURANCE INFORMATION							
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )			
Is patient a minor? ❑ Yes ❑ No	Responsible party's SS#_____						
Occupation:	Employer:	Employer address:		Employer phone no.: ( )			
Is this patient covered by insurance? ❑ Yes ❑ No							
Please indicate primary insurance	❑ Medicare	❑ AR Kids	❑ Blue Cross/Shield	❑ Other_____			
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other			
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:			
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other			

IN CASE OF EMERGENCY			
Name of local friend or relative	Relationship to patient:	Phone Number ( )	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Pro-Active Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

FINANCIAL POLICY as of 1/1/2018

ALL PAYMENTS DUE AT TIME OF SERVICE

This document is to familiarize you with our policies regarding your financial responsibility to PRO – ACTIVE REHAB, Inc. Please understand our mission is to provide you with the best, most efficient care possible and to contribute to your overall good health. As with any business, reimbursement for services rendered is expected.

Please read the following very carefully and if you have any questions, please do not hesitate to ask.

1. Co-payments for services are due on each visit. We accept cash, check, and debit/credit cards. If your check is returned for insufficient funds, we will assess an additional fee, and we will not accept further checks as payment. Furthermore, no additional treatment will be rendered until the outstanding debt is satisfied.

2. PRO – ACTIVE REHAB, Inc., will bill your insurance electronically whenever possible. This will expedite payment of your claims. If your carrier does not accept electronic billing, we will submit a paper claim.

3. Your insurance is a contract between you and your carrier. We are not a party to that contract. It is your responsibility to know and understand your benefits. While we will verify your coverage, we recommend that you contact your insurance company as soon as possible to verify and understand your benefits, including co-pays, deductibles, and co- insurance. Many insurance companies will have a co-insurance portion in addition to any co-pays and or deductibles not met. We will try to give you an estimate of the cost involved, **but this is just an ESTIMATE**. We do not know actual cost until the bill is submitted. **Pro-Active Rehab, Inc. is not responsible for any misunderstanding you have or may have regarding your benefits, including out of pocket expense. Pro-Active Rehab, Inc. will not guarantee any estimate of what you may owe. YOU ARE ULTIMATELY RESPONSIBLE FOR THE PAYMENT OF ANY UNDUE BALANCES.**

4. Not all services are covered by some insurance companies. Some insurance companies may arbitrarily select services they will not cover. These particular services will be your responsibility unless billing the insured is expressly forbidden by PRO – ACTIVE REHAB INC.'s agreement with the insurance company.

5. Medicare patients are responsible for the 20% that Medicare does not cover. It is illegal for us to waive this fee. If you have a secondary insurance we will file for you.

6. As of January 1, 2018, Congress as enacted a Medicare outpatient therapy cap in private practice facilities. This means that you are limited to $2010.00 in benefits **for 2018** to be split between physical therapy and speech therapy. We will do our best to inform you if you are endanger of exceeding your limit. **PLEASE INFORM US IF YOU HAVE RECEIVED *PHYSICAL OR SPEECH* THERAPY SERVICES AT ANY OTHER FACILITY DURING THE YEAR.**

7. If this is a work related injury, treatment will not be administered until we have received approval from your workers compensation case worker.

8. For motor vehicle accident cases it is our company policy that we do not bill auto or medical insurances, these are required to be self-pay. You will be required to pay for each visit at the time of service. Our MVA self-pay rate is $100 per visit. WE DO NOT ACCEPT ATTORNEY CASES, I.E. LIENS OR PROMISSORY NOTES. **You are ultimately responsible for any unpaid portion of your bill**.

9. **Our office requires a 24 hour notice for cancellation of appointments. There is a $25.00 charge for missed appointments without 24 hour notification to our office**.

10. Our office uses an independent collection agency for overdue bills. In the event your account becomes past due and is placed in collections, you agree to be responsible for collections fees up to an additional 50% of the amount sent to collections.

Please remember, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

CONSENT FOR TREATMENT

I agree to abide by the above stated financial policy and hereby agree to receive physical therapy treatments from PRO–ACTIVE REHAB, INC., their agents and servants, as prescribed by the referring physician or as recommended by the therapist following evaluation and established plan of care.

Signature: _____Date:_____

Witness: _____Date:_____

ESTIMATE OF PATIENT RESPONSIBILITY

The following is an estimate of the patient's responsibility physical therapy services. Pro-Active does not guarantee this information, but it is based on the information we receive when verifying your insurance coverage. Your actual financial responsibility may be more or less. We will collect a portion of your co insurance amount each visit along with any co-pay. You will be responsible for any remaining balance of the co-insurance if there is a balance remaining. If you have a credit balance, you give us permission to apply that to any outstanding accounts you may have with us. If you are due a refund, it will be issued once all your accounts are settled. **We recommend that you contact your insurance company to verify any information regarding your benefits and any out of pocket expense.** Please understand that Federal Law makes it illegal for us to waive out of pocket expenses.

As the patient or guardian, I understand the following is an estimate of my out of pocket expense for therapy. I acknowledge that the actual amount may be more or less. I further acknowledge that I am responsible for the payment of the actual patient portion, not the estimated amount if different.

I agree to abide by the terms of my insurance policy regarding deductibles, copays, and/or coinsurances.

Co Pay Amount per Visit: $_____

Co-Insurance percentage: _____

Deductible: $_____

_____ _____
Insured Signature Date

_____ _____
Pro-Active Signature Date

***Our office requires a 24 hour notice for cancellation of appointments. There is a $25 charge for missed appointments without 24 hour notification to our office. ***

Assignment of Benefits
Authorization to Pay

I hereby authorize my insurance company to make payments directly to PRO – ACTIVE REHAB, INC. for any physical therapy benefits allowable and otherwise payable to me by my current insurance policy as payment toward charges for professional services rendered. This payment will not exceed my indebtedness to PRO – ACTIVE REHAB, INC. I have agreed to pay in a timely manner any balance of professional services above this insurance payment.

PRO – ACTIVE REHAB, INC. does agree to file charges with the stated insurance company in timely manner. However, all balances must be paid within 90 days from date of service. If your insurance company has not made payment at that time, the bill will be considered past due and payment will be expected from the patient.

Pro-Active Rehab, Inc.
P.O. Box 1890
Benton, AR 72018

*Pro-Active Rehab, Inc. is
the parent company for:
Pro-Active PT- Bryant
Benton Physical Therapy
Malvern Physical Therapy

Patient Signature: _____

Insured Signature: _____ Date: _____

For Medicare Patients Only

I request that payments of authorized Medicare benefits be made to PRO – ACTIVE REHAB, INC. for any services furnished me at that facility. I authorize any holder of medical information about me to release to the Center for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient Signature: _____

Insured Signature: _____ Date: _____

PRO-ACTIVE PHYSICAL THERAPY
HIPAA POLICY

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your person medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories, that only interact with health professionals and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use of disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you chose to give consent in this document, at some further time you any request to refuse all or part of you PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Without notice, this form may be changed as rules and regulations of HIPAA evolve.

Print Name_____

Signature_____ Date: _____

PRO-ACTIVE PHYSICAL THERAPY

PERMISSION TO RELEASE INFORMATION

The people listed below are permitted to have medical information i.e.: spouse, children, etc. (Other than your doctors and insurance company.)

Name: Phone # (optional)

1._____

2._____

3._____

4._____

Do you have voicemail? Yes_____ No_____
May we leave a message on your voicemail? Yes_____ No_____

May we leave a message at your place of employment? Yes_____No_____

I agree to allow the staff at Pro-Active Physical Therapy to electronically send me education/information/questions regarding my condition care. Yes____ No ____

Pro-Active Physical Therapy/ Benton Physical Therapy/ Malvern Physical Therapy

Pro-Active Physical Therapy

PATIENT SUBJECTIVE HISTORY

NAME:_____ **AGE:**____ **HT:**_____**WT:** _____ **REFERRING DR:**_____

To better serve your individual needs please complete the following. Circle the appropriate choice(s) when indicated.

1) What is your main complaint or problem?_____

Date of onset _____ How did it occur_____

_____

Date of surgery _____ Type_____

2) If you have pain, please circle those words which best describe it.

Constant Intermittent Sharp Dull Burning Throbbing Twinge Ache Numb Tingle Tight Pulling

3) Please rate the level of your pain: (No Pain) *0 1 2 3 4 5 6 7 8 9 10 (Extreme Agony)*

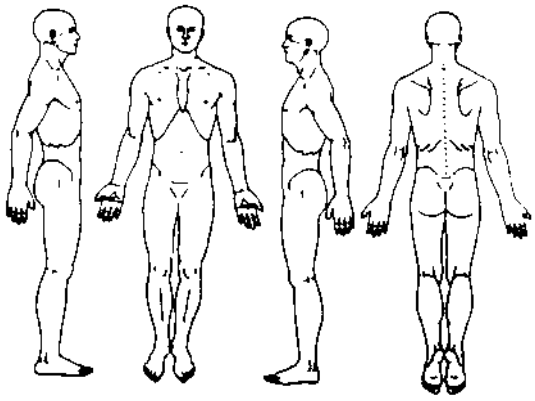
4) When do you feel: Better: Morning Afternoon Evening Night

Worse: Morning Afternoon Evening Night

5) What positions or activities make your pain better?_____

6) What positions or activities make your pain worse?_____

7) Please indicate painful areas by shading models.



8) What tests and/or treatment have you had for this problem? What were the findings?

*X-ray:*_____

MRI: _____

CT Scan: _____

Myelogram: _____

EMG: _____

Other _____

9) What medication(s) are you taking for this problem? Please List the names of the medications:

Anti-inflammatory Pain killer Muscle relaxer Other: _____

10) What is your occupation?_____

a) Working: *Full-time Part time Light duty Not working*

b) Physical work requirements: *sedentary light moderate heavy very heavy*

c) Job requires prolonged: *sitting standing bending walking lifting squatting driving*

11) What functional activities are you currently having problems with?

*dress/bathe job duties housework cook/eat walk stand sit drive sleep recreation*_____

12) Do you have any medical problems?

*heart blood pressure diabetes cancer arthritis seizures other*_____

13) Language preferred:_____**Learning preference:** verbal visual other:_____

14) If female are you currently pregnant or trying to be? Yes No

15) Do you have another appointment with your doctor? Yes No When_____

16) What do you hope to accomplish with physical therapy treatments?_____

_____

Thank You!

MEDICATION LIST

Do you take medications daily? Yes _____ No _____

Medication	Dosage	How Often?	Taking for

If you have a list of medications please give to front desk to make a copy.