
# PATIENT REGISTRATION CERTIFICATE AUTHORIZATION (Medicare)

**GUARANTOR/INFORMATION**
**IF OVER 18**

PATIENT NAME: _____

ADDRESS: _____

BIRTHDATE: _____ PHONE NO: _____

PATIENT CELL#: _____

EMAIL ADDRESS: _____

SEX: _____

EMPLOYER NAME: _____

EMERGENCY CONTACT:_____

PHONE NUMBER:_____

**PATIENT INFORMATION**
**IF UNDER AGE 18**

PATIENT NAME: _____

BIRTHDATE: _____ PHONE NO: _____

SEX: _____

**PLEASE, READ THE AGREEMENT ON THE BACK OF THIS PAGE**

I have read the statement on the front and back of this document and fully understand my obligation toward Progressive Therapy Center, Inc. as well as the conditions upon which these services are provided. Patient acknowledge receipt of a copy.

**SIGNATURE:**_____ **DATE:** _____

**Guarantor Agreement**: I agree to pay all charges connected with this treatment not covered by any insurance program sponsorship or other third party coverage I may have. I understand I am obliged to pay the patient responsibility portion of the bill immediately.
I understand that Progressive Therapy Center, Inc. assumes no responsibility for patient's personal items or valuables.
Any returned checks shall incur a $25.00 reprocessing fee assessed to my account. Long distance telephone charges incurred to verify insurance coverage for the patient will be the responsibility of the patient to pay if not otherwise covered by the insurance carrier.
**I understand that my appointment will be the time reserved exclusively for me, and is not available to anyone else. If I should find it impossible to keep my appointment, I will notify your office within 24 hours prior to my appointment. I understand that failure to do so will result in a $25.00 charge for this missed appointment.** _____

## TO ALL LITIGATION PATIENTS WHO HAVE PRIOR APPROVAL FROM OUR OFFICE FOR TREATMENT:

Patients who are being treated with the understanding that their charges will be held in pending until the settlement of their court case must furnish this office with a Letter of Guarantee form their attorney prior to initial treatment and sign an agreement stating that the patient clearly understands that the balance outstanding in our office is due upon settlement whether or not the suit is in favor of the patient or the other party or parties involved. This balance becomes **due in full** upon settlement of the case and is the sole responsibility of the patient.
NO PATIENT WILL BE TREATED FOR MORE THAN TWO WEEKS WITHOUT A SIGNED LETTER OF GUARANTEE IN OUR FILES "EXCEPT ON A CASH BASIS ONLY".

## TO ALL WORKER'S COMPENSATION PATIENTS:

If Workmen's Compensation insurance coverage can be verified, all patients treated by our office for injuries sustained while on the job will have their treatment charges billed directly to the insurance carrier monthly. Prior to treatment under this classification, employment, insurance coverage and all information pertaining to your claim will be verified. It is the responsibility of the patient to furnish our office with the necessary information and name(s) in order for our office to verify coverage.
***NOTE: If your Workmen's Compensation claim is in litigation, a Letter of Guarantee from your attorney will be necessary in order for this office to hold your account balance in pending until settlement is reached, otherwise you will be treated on a **cash only** basis. Our office will also request your personal insurance carrier information. If a settlement is reached and it is not to your advantage, payment will then be DUE IMMEDIATELY from the patient. If you cannot pay the balance in full at that time, you will be required to make monthly payments agreed upon with our office and a signed agreement will be required in order to avoid legal action. IT IS THE RESPONSIBILITY OF THE PATIENT TO PAY THE TREATMENT CHARGES AT THE TIME OF A SETTLEMENT WHETHER OR NOT THE SETTLEMENT IS IN YOUR FAVOR.

**Consent for Treatment:** I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist, or physician, may be considered necessary or advisable while a patient at Progressive Therapy Center, Inc.
I recognize that Progressive Therapy Center, Inc. is a teaching and research facility and that my treatment and care will be observed, and in some cases aided, by students from institutions of higher learning under supervision by their licensed therapists. I consent to the use of all of my medical data for educational and research purposes at the discretion of Progressive Therapy Center, Inc. _____

# OFFICE FINANCIAL POLICY

*Thank you for choosing us as your health care provider. We are committed to your treatment being successful.*

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the therapist.

*PAYMENT IS DUE AT TIME OF SERVICE.*
*WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD*

***Regarding Indemnity Insurance***
As a courtesy to you, we will gladly file all necessary insurance forms for you. It is our policy to accept the "allowable/reasonable/customary" charges as indicated by your insurance carrier. However, you are responsible for any deductibles, co-insurance, amounts in excess of your policy maximum provisions, and/or any amounts otherwise not payable by your insurance carrier. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract.

*IF YOUR INSURANCE COMPANY HAS NOT PAID YOUR ACCOUNT IN FULL WITHIN 90 DAYS, YOU WILL BE BILLED.* Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

***Regarding Insurance Plans where we participate as a provider,*** all co-pays and deductibles are due at time of treatment. We do require a minimum payment for a deductible that has not been met of $90.00 for the **initial evaluation** and $75.00 for the following visits. From the third treatment on, you will be responsible for your estimated co-insurance amount or co-pay at the time of service. In the event that your insurance coverage changes to a plan where we are not participating as a provider, refer to above paragraph.

If this is a third party liability claim, i.e. auto accident, slip and fall, etc., our office policy is to file with ALL insurance policies (auto and health policies) you are covered by. Any outstanding balance may be held in pending until the settlement of your court case providing Progressive Physical Therapy Center gives prior approval and, you and your attorney have furnished this office with a Letter of Guarantee/Protection and Assignment of Proceeds. YOU WILL BE RESPONSIBLE FOR PAYMENT OF YOUR ACCOUNT IN FULL REGARDLESS OF ANY INSURANCE YOU MAY HAVE AND/OR ANY SETTLEMENT YOU MIGHT RECEIVE.

***Interest***
We reserve the right to charge interest in the amount of 1.5% per month as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ Date_____
Signature of Patient or Responsible Party

To all patients with Medicare Primary Insurance and does not have a secondary insurance for the 20% remaining you will be responsible for the 20% that Medicare does not cover.

X_____ Date_____
Signature of Patient or Responsible Party

***Medical Information Release***: I authorize the release of any medical information necessary to process this claim.

X_____ Date_____
Signature

***Assignment***: I authorize payment of medical benefits to Progressive Physical Therapy Center, Inc.

X_____ Date_____
Signature

# NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

### Progressive Therapy Center's (Progressive PT Center) Legal Duty

Progressive Therapy Center is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### USES AND DISCLOSURES OF HEALTH INFORMATION

Progressive Therapy Center uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluation of the quality of care that we provide. For example, Progressive Therapy Center may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Progressive PT Center may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Progressive Therapy Center's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Progressive PT Center may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

### PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Progressive Therapy Center will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

### CONCERNS AND COMPLAINTS

If you are concerned that Progressive Therapy Center may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the phone number listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on

Progressive PT Center’s health information practices, or if you have a complaint, please contact anyone of our staff members.
I have read and fully understand Progressive Therapy Center’s Notice of Information Practices. I understand that Progressive Physical Therapy Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ABC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Progressive Physical Therapy Center’s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

Medication

_____
_____
_____
_____
_____
_____
_____

Have you ever had a history or problems related to any of the following? If so, please describe all yes answers.

Blood Clots No Yes _____
Lungs, Breathing No Yes _____
Heart Problem No Yes _____
Diabetes No Yes _____
High Blood Pressure No Yes _____
Bleeding Problems No Yes _____
Numbness/tingling No Yes _____
Blackout/fainting No Yes _____
Psychological problems No Yes _____
Aids No Yes _____
Cancer No Yes _____
Arthritis No Yes _____
Tuberculosis No Yes _____
Epilepsy No Yes _____
Osteoporosis No Yes _____

Patient Signature_____ Date_____

How and from whom did you hear about Progressive Therapy?

Friend: _____
Family: _____
Insurance: _____
Physician: _____
Physician's Front Office: _____
Internet: _____
Other: _____


# MEDICARE COVERAGE

Please note: If you are receiving skilled Home Health services from an agency outside of Progressive Physical Therapy (nursing or rehab), you are not eligible for outpatient therapy services covered by Medicare. If you are covered by an HMO policy, you must contact your provider for authorization of services.

The cost of this program is 80% reimbursable by Medicare coverage. The remaining 20% therapy charge will be submitted to your supplemental insurance for reimbursement. Any portion of the total charge not reimbursed by Medicare or your supplemental insurance will be your responsibility.

Medicare requires all patient's to return to their referring physician every 30 days for an updated prescription.

You may elect to pay privately for this service. The charge for private therapy can be discussed with the office director and/or administration.

**Are you presently receiving skilled Home Health Service?**

YES _____ NO _____

**Are you presently covered by an HMO insurance policy?**

YES _____ NO _____

If you change insurance carrier, please give a copy of your new card to our front office staff so that we bill the correct insurance company.

Patient Height:_____ Weight:_____ (required by Medicare)

Patient Signature Date

_____ _____