Durant
Physical Therapy

REGISTRATION FORM

Today's Date: Referring Physician:

PATIENT INFORMATION

Patient's last name: First: Middle: Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Birth date: / / Age: Sex: ☐ Male ☐ Female Social Security no.:

Street address: City: Home phone no.:

P.O. Box: State: Zip: ( )

Occupation: Employer: Employer phone no.: ( )

Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

How will this account be billed ☐ Private Insurance ☐ Workers Compensation ☐ Private Pay

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If the primary subscriber is someone other than yourself (patient) please list the following:
Policy Holders Name: Social Security no: Date of Birth:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

HEALTH HISTORY

Have you received any physical therapy this calendar year? ☐ Yes ☐ No

If yes, where were the services rendered and how many sessions did you attend? _____

Are you currently receiving home health services? ☐ Yes ☐ No If yes, please list the agency that is treating you _____

List medications you are currently taking?

_____

_____

_____

Briefly describe the reason, condition, and/or accident that has brought you to our office:

_____

_____

_____

Have you experienced any recent falls? ☐Yes ☐No If yes, how many falls?_____ Did it result in injury? ☐Yes ☐No

When is your next scheduled doctors appointment? _____

Please check any of the following health conditions, surgical procedures, injuries, or diagnostic tests that you have had in the past or present time.

CONDITION

- ☐Asthma
- ☐Diabetes
- ☐High Blood Pressure
- ☐Lung Problems
- ☐Cancer
- ☐Seizures
- ☐Arthritis
- ☐Bladder/Bowel Incontinence
- ☐Stroke CVA
- ☐Lung Problems
- ☐Fractures/Broken Bones
- ☐Tingling/Numbness
- ☐Frequent Headaches
- ☐Blood Clots
- ☐Dizziness
- ☐Joint Swelling
- ☐Other

Diagnostic Tests

- ☐ MRI ☐X-Ray
- ☐CT Scan ☐EMG

SURGICAL PROCEDURES: Please explain in space provided

- ☐Joint Replacement
- ☐Orthopedic Surgery
- ☐Heart Surgery
- ☐Spinal Surgery
- ☐ Other Surgeries

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The team at Durant Physical Therapy is pleased to be a part of your rehabilitation experience, and we thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

INSURANCE BILLING

We will gladly call your insurance company to identify your current benefit coverage. However, please understand that insurance companies will not guarantee medical benefits over the phone. We can only use this information as an estimate guideline. Actual determination is made after we receive written notification and/or payments on your claim. We strongly encourage you to contact your insurance company directly in order to understand your plan's coverage and limitations. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

WORKER'S COMPENSATION

We strive to work with physicians, employers, adjusters, and nurse case managers to provide the best quality care necessary to restore your optimal rehabilitation potential. All insurance carriers require a prior approval of treatment before services can be rendered. It is your responsibility as the claimant to provide our office with all pertinent contact information. Please be prepared provide us with names of the insurance carrier, adjuster, nurse case manager, attorney, telephone and fax numbers, date of injury, surgery date, and claim number.

PAYMENTS

All deductibles, co-pays, co-insurance and cash pay amounts are due at the time of service, unless other written arrangements are made with our facility.

Any unpaid balance on your account after 120 days without financial arrangements my be subject to legal collection proceedings and a 35% collection fee will be added to your outstanding bill. Please do not hesitate to ask us any questions or request a copy of your account balance.

PATIENT RIGHTS & GRIEVANCE

Patients utilizing rehabilitation services are entitled to:

- Licensed/ certified clinicians to evaluate all admissions and if deemed necessary and reasonable, initiate an appropriate plan of treatment under the order of the physician.
- A clean, safe, healthy environment and proper infection control procedures as determined by clinical guidelines.
- Assessment of functional levels using appropriate evaluative techniques.
- Protection of privacy and confidentiality.
- Patient teaching and/ or family education as each individualized treatment process for his/her admission through discharge.
- Inclusion of the patient and patient's family in the physical setting, expectations, outcomes, treatment programs and scheduled therapy services.
- Be treated with consideration, respect, and full recognition of dignity and individuality.
- Voice grievances regarding treatment of care that is (or fails to be) furnished or regarding the lack of respect by anyone furnishing services and must not be subjected to discrimination or reprisal for doing so. Grievances my be reported to the client relations specialist or clinical director.

Again we appreciate your choosing Durant Physical Therapy & Aquatic Center.

By signing this form, I the patient (or legal guardian of the patient), have read, understood and agree that I am 100% responsible for all fees incurred at Durant Physical Therapy, attendance policy, rights and grievance, and HIPPA privacy notice. I agree to authorize Durant Physical Therapy to release my medical information to insurance companies, physicians, nurse case managers, attorneys and to all other pertinent parties that may be involved in my claim or care. I also agree to assign benefits to Durant Physical Therapy, INC.

Patient Name (Please print) Date

Patient Signature (or Legal Guardian) Date