# EXSTROM PHYSICAL THERAPY

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**Denise Exstrom Larsen**
**Physical Therapist**

**Jami Tomasek, DPT**
**Physical Therapist**

## PATIENT REGISTRATION

*****Please fill out all information as completely and accurately as possible.*****

*All information is confidential and is used for internal purposes only and not released to any 3rd parties other than for the purpose of billing and communication with appropriate healthcare providers*

### PATIENT INFORMATION

☐ Updated Info

**First Name** _____ **Preferred Name** _____ **Middle Initial** ____ **Last Name** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Home Phone #** _____-_____-_____

**Cell Phone #** _____-_____-_____

**Work Phone #** _____-_____-_____ **Ext** _____

**Preferred Contact Number** (check one)
◯ **Cell** ◯ **Home** ◯ **Work**

**Birthdate** _____/_____/_____ **Social Security #** _____-_____-_____

**E-Mail** _____

### PAYMENT TYPE

☐ **General Insurance** ☐ **Worker's Compensation** ☐ **Medicare** ☐ **Medicaid** ☐ **Self Pay**
☐ **Accident/Liability** ☐ **United Healthcare** ☐ **Secure Horizons** ☐ **Railroad Medicare**

### ACCOUNT RESPONSIBLE PARTY INFORMATION (if different from patient above)

**First Name** _____ **Last Name** _____

**Address** _____ **City** _____ **State** _____ **Zip** _____

**Birthdate** _____/_____/_____ **Social Security #** _____-_____-_____

### EMPLOYER INFORMATION (if not employed, responsible party's employer)

**Employer** _____

**Address** _____**City** _____ **State** _____ **Zip** _____

**Phone #** _____-_____-_____ **Worker's Comp Contact** _____

### EMERGENCY CONTACT INFORMATION (nearest relative not residing with you)

**Name** _____ **Relation** _____

**Phone #** _____-_____-_____ **Cell Phone #** _____-_____-_____

### WORKERS COMP/ACCIDENT/LIABILITY INFORMATION (**ALL** info required for proper billing of other insurance)

**Insurance Name** _____ **Phone #** _____-_____-_____

**Billing Address** _____ **City** _____ **St** _____ **Zip** _____

**Claim Number** _____

**Attorney** _____ **Phone #** _____-_____-_____

### PRESENCE AT CLINIC (If someone, friend or family, calls or visits and asks about you may we make your presence known?)

☐ Yes ☐ No

### HOW DID YOU HEAR ABOUT US?

☐ **Friend** ☐ **Family Member** ☐ **Doctor** ☐ **Internet Search** ☐ **Phonebook**
☐ **Advertising** ☐ **Billboard** ☐ **Past Patient** ☐ **Other** _____

**MEDICARE PATIENTS ONLY Medicare Second Payer Questionnaire (Completed by ALL Medicare Patients)**

1. Is the patient a Veteran? **YES NO**
   If YES, does the patient authorize Exstrom Physical Therapy to bill the Veterans Administration? **YES NO**

2. Is this medical condition due to an accident of any kind? **YES NO**
   If YES, Was it work related? **YES NO**
   Auto accident? **YES NO**
   Injured at home? **YES NO**
   Other? _____ **YES NO**

3. Is this medical condition covered by another health plan through the patient's current employer or their spouse's employer? (Other than retiree coverage) **YES NO**

## MEDICAL CONSENT

I consent to the healthcare rendered to me (or the person to whom I am legally responsible) that is determined to be necessary by the physical therapist and/or physician within their respective scopes of practice.

_____ _____ _____/_____/_____
Print Sign Date

## HIPAA CONSENT

I have read or declined to read and hereby agree to the HIPAA Notice of Privacy Practices set forth by Exstrom Physical Therapy to use and disclose my protected health information for the process of carrying out treatment, payment activities and healthcare operations. I understand that I have the right to revoke this consent in writing at any point, but doing so may hinder continuation of treatment and insurance billing practices as well as other healthcare operations associated with my care which may leave me personally responsible for any unpaid account balances as a result and will not cover any information that has already been released for purposes previously disclosed.

***I also understand to release medical information/presence at clinic to outside persons or entities (spouse, family member, etc) other than physician or insurance; I must declare and sign an Authorization to Disclose form before information can be disseminated.***

_____ _____ _____/_____/_____
Print Sign Date

## FINANCIAL AGREEMENT

I hereby authorize the release of any medical information to any entities necessary to process my claims for billing or authorization of visits. I also authorize payment of benefits to Exstrom Physical Therapy. I agree that I am aware of my insurance coverage and requirements for receiving outpatient physical therapy services and agree to assume **any and all** responsibility for any balance, co-pay or deductible not paid by my insurance company, Medicare or Workers Compensation. I understand that Exstrom Physical Therapy may NOT participate with my insurance company. I agree to assume **any and all** responsibility for non-participating insurance companies. A late fee of 18% per annum will be applied to all past due accounts.

_____ _____ _____/_____/_____
Print Sign Date

## ATTENDANCE AGREEMENT

I understand that my involvement in therapy and compliance with my home exercise program are critical to my success in meeting my therapy goals. I understand that my attendance is required. If I must cancel an appointment I will do so at least 24 hours prior to the appointment. My therapist(s) and I will make every effort to reschedule that session for the same week. Exstrom Physical Therapy reserves the right to discontinue treatment if I habitually cancel or fail to show up for scheduled appointments. IF A TOTAL OF 3 NO SHOWS ARE RECEIVED, I WILL BE PUT ON "SAME DAY SCHEDULING" STATUS. Additionally, I understand that all cancellations and no shows will be documented in my medical record.

_____ _____ _____/_____/_____
Print Sign Date

## PERSONAL REPRESENTATIVE

If any of the above has been signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name _____

Relationship to the Patient _____