New Patient Registration

Today's date: / /

Full name | Pronouns | Date of birth

Address

City | State | Zip

Primary phone | This is ❑ mobile ❑ home ❑ work

Secondary phone | This is ❑ mobile ❑ home ❑ work

Fax

Email

Emergency contact name | Relationship to client

Emergency contact phone | This is ❑ mobile ❑ home ❑ work

REFERRAL INFORMATION

Referring doctor | Contact information

Primary care doctor | Contact information

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Centurion Physical Therapy to provide medical care and treatment considered necessary and proper for my physical condition.

Client signature (or guardian) | Date

MEDICAL INFORMATION

Briefly tell us why you're here:

Please list all medications you're currently taking:

Please list all current and past medical conditions, as well as any other information that might assist us in your care:

E-MAIL CONSENT

New regulations require that anyone using e-mail to communicate with healthcare providers understand and agree to the certain conditions and limitations.

1. The transmission of patient information via e-mail has a number of risks including but not limited to: e-mail is not secure and can be intercepted, misaddressed, altered, or used without authorization or detection; e-mail may be circulated, forwarded, stored in paper and electronic files even after the sender or recipient has deleted their copy.

2. Centurion Physical Therapy will use all reasonable means to protect the security of the e-mail, however we cannot guarantee e-mail confidentially. Centurion is not liable for improper disclosures unless they are caused by our intentional misconduct.

I have read and understand this email disclaimer and give consent to Centurion Physical Therapy to correspond with me via e-mail, if necessary.

Client signature (or guardian) Date

CANCELLATION POLICY

We take pride in our promptness, courtesy, and attention to detail. In order to provide you and all our clients with quality care, we need to make our time as productive as possible. In this regard, we must charge for no-shows and last minute cancellations.

We require a 24-hour cancellation notice or you may be subject to the full fee.

Client signature (or guardian) Date

INSURANCE INFORMATION

Insurance carrier

Policy number | Group number

Policy holder name | Date of birth

Relationship to client | Employer

FINANCIAL POLICY STATEMENT AND ASSIGNMENT OF BENEFITS

Centurion Physical Therapy will submit insurance claims to your insurance provider on your behalf; however, we do expect payment at the time of service. Charges for home equipment, extra treatment time, and consultation may be additional. Treatment may not be covered by your health care plan or insurer without a referral from a physician, and such treatment may be a covered expense if rendered with a referral. I understand that I am directly responsible for all charges incurred for myself and my dependents, regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe.

I understand that I will be reimbursed directly from my insurance carrier for use of out-of-network benefits, and I hereby authorize and request that in-network insurance company benefits be paid directly to Centurion Physical Therapy for any medical services rendered to me or a member of my family. I fully understand this agreement and my consent will continue until cancelled by me in writing.

Client signature (or guardian) | Date

RELEASE OF INFORMATION

I hereby authorize Centurion Physical Therapy to release all information necessary, including medical records, to Medicare, Medicaid, or private insurance carriers and/or its representatives in order to secure payment. I understand that it is mandatory to notify the healthcare provider of any other party who may be responsible for paying for my treatment.

Client signature (or guardian) | Date

CREDIT CARD ON FILE

We require payment in the form of check or credit card at the time of your visit. If you would like to keep a credit card on file to be charged after each visit, please provide the following information:

Credit card number | Expiration | CVC

Name on card | Billing zip code

By signing you are authorizing Centurion Physical Therapy, PC to charge your credit card for the services rendered in the office.

Cardholder signature | Date

HIPAA NOTICE OF PRIVACY PRACTICES

The privacy of your medical information is important to us. The US government regulators established a privacy rule through the Health Insurance Portability and Accountability Act (HIPAA), governing protected health information. The attached notice tells you about certain rights you have. Please read it carefully and sign below to acknowledge receipt.

Client signature (or guardian) | Date