

**CHAPIN & HAVLICEK PHYSICAL THERAPY, LLC**

**FOR OFFICE USE ONLY:**

ACCOUNT # \_\_\_\_\_ PT ID# \_\_\_\_\_ DATE: \_\_\_\_\_  
THERAPIST: \_\_\_\_\_ LOCATION: \_\_\_\_\_ NEW PATIENT: Yes \_\_\_ RETURNING: Yes \_\_\_  
DIAGNOSIS: \_\_\_\_\_ MD: \_\_\_\_\_

**PATIENT REGISTRATION FORM (PAGE 1 OF 3)**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
LAST FIRST M.I. (MM/DD/YY)

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email address: \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_ Marital Status: S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_

Emergency Phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Name of Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Patient is:** minor \_\_\_ student \_\_\_ retired \_\_\_ self employed \_\_\_ currently employed \_\_\_ unemployed \_\_\_

**EMPLOYMENT SECTION**

Employer Name: \_\_\_\_\_ Work phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EXT. \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**If you are a Student:** Name of School: \_\_\_\_\_ Address: \_\_\_\_\_

**HEALTH INSURANCE:** Health Insurance information must be provided under all circumstances.

Please inform us of all insurance coverage that you carry at this time.

**Primary Health Insurance:** \_\_\_\_\_ ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

Primary Insured Person's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # of insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other Dependent \_\_\_

Employer of insured: \_\_\_\_\_

Street Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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**Secondary Health Insurance:** \_\_\_\_\_ ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insured Person's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security # of insured: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other Dependent \_\_\_

Employer of insured: \_\_\_\_\_

Street Address of Employer: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medicare Patients** must supply **DATE OF LAST VISIT TO M.D.:** \_\_\_\_\_ (MM/DD/YY)

Please list all of your doctor's and their addresses to whom you would like reports sent:

HAVE YOU EVER RECEIVED PHYSICAL, OCCUPATIONAL THERAPY OR CHIROPRACTIC CARE FOR THIS CONDITION? Yes \_\_\_ No \_\_\_ This year? Yes \_\_\_ No \_\_\_

\*\*\*\*\* REQUIRED INSURANCE CLAIM INFORMATION\*\*\*\*\*

IS YOUR CONDITION: Medical Problem \_\_\_ Worker's Comp \_\_\_ Motor Vehicle Accident \_\_\_ Other accident \_\_\_

If an accident, Insurance Carriers require: Date of Accident/Injury: \_\_\_\_\_ State Accident took place in: \_\_\_\_\_

Is this a school sports injury? Yes \_\_\_ No \_\_\_ If yes, have you notified the school? Yes \_\_\_ No \_\_\_

School Insurance (if applicable): \_\_\_\_\_

**WORKER'S COMPENSATION:**

Has this injury been reported to your employer? Yes \_\_\_ No \_\_\_

Is this injury disputed as Worker's Compensation by employer? Yes \_\_\_ No \_\_\_

Company Name: (at time of injury) \_\_\_\_\_

Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

W/C Insurance: \_\_\_\_\_ Claim#: \_\_\_\_\_ Phone#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Adjuster: \_\_\_\_\_ Nurse: \_\_\_\_\_

**AUTOMOBILE ACCIDENT SECTION:**

Has the accident been reported to your AUTO INSURANCE Company? Yes \_\_\_ No \_\_\_

Do you have an attorney for this accident? Yes \_\_\_ No \_\_\_

Is this accident/injury currently a lawsuit? Yes \_\_\_ No \_\_\_

*If not currently a lawsuit, if at any time in the future this becomes a lawsuit, it is the patient's responsibility to notify this office of all attorney information regarding representation in this accident.*

Name of Auto Insurance Company: \_\_\_\_\_ Claim#: \_\_\_\_\_

Company Address: \_\_\_\_\_

\*\*\*we will need a copy of auto insurance card for your chart\*\*\*

Policy #: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Patient is policy holder's: Spouse \_\_\_ Child \_\_\_ Other Dependent \_\_\_ Self \_\_\_ No relation \_\_\_

Does your Auto Insurance Policy provide medical coverage (med-pay): Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Are Auto Medical Benefits exhausted for this auto accident: Yes \_\_\_ No \_\_\_ Unsure \_\_\_

Insurance Adjustor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

**ATTORNEY INFORMATION:** Complete for any litigation pertaining to injury.

Attorney Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

Attorney Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must complete our Registration/Insurance Form before seeing the therapist. This is page 3 of 3 Intake documents required.

**Co-Pays are due at time of service:** As you arrive for each appointment, please check in at the front desk and pay your copay. You are responsible for payment of all copays, deductibles and co-insurance associated with your insurance plan.

Regarding Insurance – The balance of your account for treatment **rendered is your responsibility whether reimbursement from other sources such as insurance coverage, workers compensation, motor vehicle insurance, or litigation may exist.** 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 party to that contract. **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 carrier programs.**

**Changes in Your Insurance Coverage** – It is the patient’s responsibility to inform this office of any and all changes of insurance coverage during the course of treatment. It is your responsibility to inform us that your insurance coverage is about to change so that we can verify your benefits and obtain prior authorization as required. Failure to provide this information will result in the patient being responsible for payment of all non-covered and/or unauthorized services.

**Usual and Customary Rates** – Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company arbitrary determination of usual and customary rates.

**Referral** - As per your coverage, it is the patient’s responsibility to obtain a referral for physical or occupational therapy. No referral on file may result in denial of insurance coverage for some or all of your treatment received. Please contact your insurance carrier immediately and review your insurance contract requirements for your plan. Chapin & Havlicek Physical Therapy does not accept responsibility for any insurance carrier errors or misinformation supplied to either the patient or Chapin & Havlicek Physical Therapy, LLC.

**Authorization Received** – Authorization to treat received from your insurance carrier, does not guarantee payment for services rendered. **Should there be a portion established by your insurance carrier as “due from patient,” that balance is your responsibility.**

**Adult patients** – Adult patients are responsible for full payment of their account regardless of other reimbursement possibilities.

**Minor Patients** – The parents (or guardians of the minor) are responsible for full payment of the minor child’s account regardless of other reimbursement possibilities.

**Fee for NSF Checks** – There is \$25.00 charge for Non-Sufficient Funds Checks received as payment from patients.

**Interest Charge** – Interest automatically is accrued to accounts for unpaid charges over 90 days past due at 1.5% per month.

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

**PATIENT (Responsible Party) SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**\*\*\*PAYMENT AUTHORIZATION\*\*\***

I authorize payment of medical benefits to the supplier, Chapin & Havlicek Physical Therapy, LLC for services rendered.

**PATIENT (Responsible Party) SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**\*\*\*PATENT RELEASE OF INFORMATION\*\*\***

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignments below. (Reference HCFA Health Insurance Claim Form Box 12)

**PATIENT (Responsible Party) SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**

**To our patients: Please provide us with your insurance cards and license to be copied for your chart. If at any time you would like to have a member of our insurance staff meet with you privately to discuss your insurance or account balance, please request at the front desk. Our staff would be happy to assist you in the any way possible. Thank you.**