EMAIL AUTH ______________

NORTH POLE PHYSICAL THERAPY REGISTRATION

PATIENT NAME ____ **DOB** ___________________________ **M/F**______________

SS# ______________________________ **PRIMARY PHONE#** ________________________________
CELL#______________________________

MAILING ADDRESS ____

____
____

EMAIL ____ **HOW DID YOU HEAR ABOUT US?** __________________________________

CURRENT EMPLOYER ____ **PHONE** ____

ADDRESS ____ **JOB TITLE** _______________________________________

EMERGENCY CONTACT ____ **PHONE** ____

RESPONSIBLE PARTY (PARENT/GUARDIAN SIGNING PAPERWORK) DOB: ___________________________________

PLEASE LIST ANY PERSON(S) YOU WISH TO AUTHORIZE TO SPEAK WITH NPPT REGARDING YOUR ACCOUNT PER HIPAA GUIDELINES:____
____

PRIMARY INSURANCE/WORK COMP CO ____

INSURANCE ADDRESS ____

ID # ____
GROUP____

POLICY HOLDER/SPOUCE NAME __________________________ **POLICY HOLDER DOB** ____________
ADDRESS_______________________________

W/C ADJUSTER NAME & PHONE ____________________ **BODY PART** ______________________ **OPEN & BILLABLE** __________________

FOR OFFICE USE: EFFECTIVE DATE _______________________ DEDUCTIBLE $_________________________ MET $___________________________

OUT OF POCKET MAX $_____________________________ MET $__________________________________LIMITATIONS _______________________

COPAY/COINS _________________ SCRIPT REQ: _____Y/N_____ PRE-AUTH REQ : ____Y/N____

SECONDARY INSURANCE ____

INSURANCE ADDRESS ____

ID OR SSN# ____
GROUP____

EMAIL AUTH ______________

POLICY HOLDER/SPOUCE NAME ____________________________ POLICY HOLDER DOB ___________ ADDRES ____________________

FOR OFFICE USE:

EFFECTIVE DATE ___________________________________ DEDUCTIBLE $___________________________ MET $____________________________

OUT OF POCKET MAX $____________________________ MET $_______________________________LIMITATIONS ____________________

COPAY/COINS ________________________ SCRIPT REQ : _____Y/N___ PRE-AUTH REQ : ____Y/N____

I HAVE REVIEWED AND ADDED/MADE ANY CORRECTIONS TO THE ABOVE INFORMATION. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS REGARDING THE ABOVE INFORMATION.

SIGNATURE ____ DATE ____________________________

Consent for Physical Therapy

I consent to physical therapy evaluation and treatment provided by North Pole Physical Therapy. Physical therapy includes tests and treatment ordered by my physician or deemed necessary by the physical therapist. The practice of medicine is not an exact science. No guarantees have been made to me about the results of tests or treatment.

I am aware that I may experience soreness and possibly pain with physical therapy testing and treatment. The therapist will do all to ensure my comfort. I realize that it is my responsibility to inform my therapist of any soreness or pain I experience during therapy sessions or during a home exercise program.

I have read this consent for physical therapy and agree to its terms.

SIGNATURE ____ **DATE** ______________________________

NO SHOW: If you fail to cancel your appointment **24 hours** in advance, you may be billed a **$15.00 no show fee** which cannot be billed to your insurance. **If you miss more than three appointments by cancels OR no shows you may be placed on a same day call-in basis.**

___________ **(Patient/Responsible Party Initials)**

Remember You are ultimately responsible for your bill.

- **Private** If you have private insurance, as a courtesy we will bill your primary and secondary carriers for our services. If your insurance pays and there is still an outstanding balance, you will be billed. Remember that insurance is a contract between you and your insurer. We will be happy to help as we can send records, but will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or so-called "usual and customary" reductions**. COPAYS ARE DUE EACH VISIT. DEDUCTIBLES AND CO-INSURANCE ARE DUE FOLLOWING EACH VISIT OR WEEKLY UNLESS ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENENDERED.**
- **Medicare** Remember that you do have a co-payment and a deductible; we request that you pay this once a month with your monthly statement.
- **Veteran's Administration** Patients are required to get pre-authorization before your first visit if you would like the VA to pay. Our staff can assist you with further authorizations if you wish.
- **Workman's Compensation** If you would like us to bill your workman's compensation company, you will need to provide us with the claim number, name, address, phone number, and your claim adjuster's name. We will not become involved in disputes concerning authorization and or payment, and you are personally responsible for payment, in the event that your benefits are denied.
- **Auto/Personal Injury** If you wish us to bill your auto insurance company you will need to provide us with the name, address, phone number, and a claim number. We will not become involved in disputes concerning maximum benefits, responsibility, or authorizations. ***If your insurance has not paid in 60 days, you are expected to start making payments on your account***.
- **Tricare Prime** patients are required to obtain an authorization prior to services unless secondary. **There is a $31.00 copay for retiree policies due at time of service or weekly.** In the event you would choose to be seen without an authorization you will be responsible for cost-share amounts.
- **Our fees**: We use the fee guide published annually by MAG Mutual Healthcare Solutions, Inc.

I have received the HIPAA Notice of Privacy Practices from North Pole Physical Therapy.

EMAIL AUTH _______________

Patient's Agreement: I understand that it is not the responsibility of **my** insurance company to pay any bills accrued, but that it is **my** responsibility to pay all bills. In consideration of this, I agree to pay all bills that have not been paid by the insurance company **within 60 days** unless a monthly installment plan has been arranged and approved. I hereby authorize payment to be made directly to North Pole Physical Therapy for services rendered. I further authorize the release of medical records to my insurance company, Social Security Administration, its intermediaries, or carriers, to assist in reimbursement.

PRINTED NAME ________________________________ SIGNATURE ____________________________________ DATE _______________