Multisport Physical Therapy & Fitness, PLLC • 304 First St. • Liverpool, NY 13088

Physical Therapy Registration

Today's Date:_____________

Patient Information

Patient's Name: ___________________________________ Date of Birth: _______________ Age: _________

Patient's SSN: _____________________________Home Telephone:___________________________________

Address:_______________________________________ City:________________ St:_______Zip:__________

Email____

Referring MD: ___________________________________ Telephone Number:_________________________

Primary Care MD: ____________________________________ Telephone Number:_____________________

Employer:____ Work Tele:_____________________________

Emergency contact: ____Tele:____________________________

Date of Injury:_______________ Type of Injury:____

Insurance Information

Ins. Carrier: __________________________________ID#: ________________________Group#:___________

Address: ____Tele:_________________________

Subscriber's Name: ____ Self:_____ Spouse:_____ Parent:____

Subscriber's Date of Birth: ______________________ Subscribers SSN: ______________________

Secondary Insurance Information

Insurance Co: __________________________________ID#: __________________Group#:__________

Address: ____Tele:_________________________

Subscriber's Name: ____ Self:_____ Spouse:_____ Parent:____

Subscriber's Date of Birth: ______________________ Subscribers SSN: ______________________

Is this Injury Workers Compensation or Auto Related? (circle one) Is claim currently: open or closed?

Date of Injury: ____________________________ Ins. Carrier Name ______________________________

Insurance Carrier Address:____

If Worker's Comp, Adjuster's Name : ___________________________________Tel:____________________

Worker's Comp Claim Number:________________________________ Carrier Case #__________________

Office Use

Spoke with:________________________________ Covered Y/N Copay Amount:________________

Deductible Amount:_________________ Deductible Anniversary_______________ Deductible Met: Y/N

Authorization #____________________________ # Visits Authorized___________________________

It is necessary for us to keep a copy of your medical information card on file

Multisport Physical Therapy & Fitness, PLLC
304 First St.
Liverpool, NY, 13088
451-2270

Patient Name_______________________________________ Date_____________________

Reason for referral to Physical Therapy____

Date of onset, injury, surgery____

What were your initial signs and symptoms?____

What was your initial treatment? ____

Are you currently working? Yes___ No___ If no, when was your last day of work?___________

Have you ever had any other treatment for this condition? Yes__ No __ If yes explain:

____

When is your next doctor visit? _______ Are you taking any medications now? Yes ____No____

If yes, please list them and the condition for which they are being taken: ____________________

____

____

Do you now, or have you ever had, any of the following (please list approximate dates):

Diabetes	_____	High Blood Pressure	_____
Heart Disease	_____	Heart Attack	_____
Pacemaker	_____	Migraine Headaches	_____
Kidney Problems	_____	Nervous Disorder	_____
Allergies to Heat	_____	Allergies to cold/ice	_____
Hernia (Ventral, inguinal, etc)	_____	Seizures	_____
Metal Implants	_____	Dizziness	_____
Cancer	_____	Pregnant (currently)	_____

If yes to any of the above, please explain (approximate duration, symptoms, treatment, reoccurrences, etc.): ____

____

Previous Surgery:____

Any other medical condition that the Physical Therapist should be aware of:_________________

____

I certify that to the best of my knowledge, the above information is correct.

Signature______________________________________ Date____________________________

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Office Policies/Consent for Treatment

We are dedicated to providing highly individualized care for patients with orthopedic injuries. Insurance companies do not dictate the care you receive at Multisport Physical Therapy & Fitness, PLLC. Your plan of care is arrived at through the professional assessment of your therapist and physician, and is based on your specific functional goals. Please read the following policies and sign below.

1. Insurance: In order to maintain our high standard of care, Multisport Physical Therapy & Fitness, PLLC does not participate with most insurance plans. Payment is expected when services are rendered. Multisport Physical Therapy & Fitness, PLLC will provide you with an invoice which you may submit to your insurance company for your reimbursement. Please make sure that we have all your current insurance information. Patients are responsible to obtain any necessary authorization or certification required by their insurance companies.

2. Worker's Compensation: Worker's Compensation claims will be submitted directly by our office. Please provide us with all the information necessary for billing, including your claim number, date of injury, the name and telephone number of your claim adjuster, and the correct address to which we should mail the claims. Authorization is required prior to treatment. ***I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event my claim for Worker's Compensation benefits is denied.***

________________________________ ____________________
Signature Date

3. Durable Medical Equipment (DME) and Supplies: DME and supplies must be paid for at the time of your therapy session. A statement will be provided for your self reimbursement.

4. Payment: Payment is expected when services are rendered (each visit). For your convenience, we can accept payment on a weekly basis. We accept VISA, MasterCard, American Express, checks and cash. We also offer a convenient payment plan. If your insurance company does not remit payment within 60 days, the balance will be due from you. We expect accounts to be paid in full within 60 days from the last day of treatment.

5. Late Charges/Returned Checks: Any account that remains open beyond 30 days from last date of treatment will be subject to a $10.00 fee for each month that the account is not paid in full. There is a $35.00 fee for all returned checks.

6. Cancelled/Missed Appointments: If a patient is more that 15 minutes late for an appointment, we reserve the right to reschedule. Late arrivals are subject to the full fee for the session. We require 24 hour notice for cancellations. Appointments that are cancelled with less than 24 hours notice or no show appointments are subject to a $50.00 charge which is not reimbursable by insurance companies.

7. Our Pledge Regarding Medical Information: We understand that medical information about you and your health is personal and confidential. We are committed to protecting the

confidentiality of your medical information. We create a record of the care and services you receive at Multisport Physical Therapy & Fitness, PLLC. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to make sure that medical information that identifies you is kept private.

Consent for Treatment

I have read and understand the Office Policies of Multisport Physical Therapy & Fitness, PLLC and agree to the terms listed. I hereby agree to be treated by Multisport Physical Therapy & Fitness, PLLC as set forth in my treatment plan and to cooperate as expected.

______________________________ ______________________________

Signature Date

Authorization to Release Information / Assignment of Benefits

Should Multisport Physical Therapy & Fitness, PLLC submit insurance claims on my behalf, I hereby assign to Multisport Physical Therapy & Fitness, PLLC, all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other plan. This assignment will remain in effect until revoked by me in writing. A photo copy of this assignment is to be considered as valid as an original. I understand my insurance coverage is a relationship between me and my insurance company and I agree to accept financial responsibility for payment for the charges incurred. I understand that a monthly $5.00 rebilling fee will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collections and/or court costs and reasonable legal fees should this be required. I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct.

I hereby authorize said assignee to release to the insurance company(s) and / or attorney any information acquired in the course of my examination or treatment and all information necessary to secure payment. I also authorize the release of medical reports and other pertinent health information about me to my referring physician or any other medical personnel involved with my medical treatment.

I have read the above policies and understand that payment is due when services are rendered. I may be responsible for filling my own medical insurance claims. I agree to accept full financial responsibility for medical expenses incurred at Multisport Physical Therapy & Fitness, PLLC.

If patient is under 18 years of age, and a parent is not able to attend sessions of physical therapy with the minor, the parent(s) signature for authorization allows Multisport Physical Therapy & Fitness, PLLC to commence physical therapy treatments with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Patient’s Signature:______________________________________ Date:______________

Parent’s Signature: ______________________________________ Date:______________

(If patient under 18 years old)