PIEDMONT PHYSICAL THERAPY, INC.
8551 Rixlew Ln., Ste. 340 Manassas, VA. 20109
Phone 703-368-7343 FAX 703-368-0719
www.piedmontpt.com

PATIENT REGISTRATION FORM

Today's Date_____

During the past 6 months have you received any physical therapy or medical care at home? Yes____ No____

First Name_____ Middle _____ Last_____

Street Address_____Apt.#_____

City_____ State_____ Zip_____

Date of birth (mm/dd/yyyy)____/_____/_____

Home Phone_____ Work Phone_____ Cell Phone_____

Sex: Male ____ Female____ Social Security Number _____-_____-_____

Email_____(*for communication only - not shared with anyone*)

Occupation_____ Employer Name & Address_____

Emergency Contact_____ Phone_____

Is this condition a work-related injury? Yes____ No____ Due to Auto Accident? Yes____ No____

To whom may we discuss your account or medical information?

_____

To whom may we thank for referring you to our office? _____

PLEASE NOTE:
Our office will not bill third party insurances or med pay policies.
You will be required to pay at the time of service and seek reimbursement from them directly.
We do require separate written authorization to release medical records to your attorney. There is a fee involved for the production of bills and copies of the medical records.

The following information is a requirement for proper medical documentation and the insurance requires a month, a day and a year. You may use an approximate date when symptoms required treatment if an actual injury, accident or surgery did not occur.
DATE OF INJURY, ACCIDENT OR SURGERY: _____
MONTH / DATE / YEAR

AUTHORIZATIONS AND RELEASES

I authorize Piedmont Physical Therapy, Inc. to apply for insurance benefits on my behalf for covered services. I authorize Piedmont Physical Therapy to release medical information for insurance purposes. I permit a COPY of this authorization to be used in place of the original "Assignment of Benefits" and request payment of medical insurance benefits to be made directly to the practice for services rendered.

FINANCIAL RESPONSIBILITY

I have been notified and understand the following business office policies:

- I accept full financial responsibility for treatment received in this office. An approved workers compensation claim with authorization will cover the expense of treatment but **not that of cancellation or no show fees. These are the patient's full responsibility.**
- Pre-determined per office visit copays or coinsurance estimates are **due at the time of service**.
- If my policy covers a percentage of my bill, I will be asked to pay that estimated percentage at the time of each visit. If there is a balance remaining, payment is due within **30 days from the date I am billed.**
- I understand I may only receive one statement prior to having my account processed for collection. Attempts will be made to contact you directly prior to any collection action.
- Primary insurance claims will be filed at no extra charge.
- It is the responsibility of the patient to obtain proper physician referrals & prescriptions.
- Account balances are subject to a monthly service charge of 1.50%.
- If additional charges are incurred in an attempt to collect any unpaid balances, the actual and reasonable collection charges and legal fees will be added to delinquent accounts and the financially responsible party is responsible for all monies due.
- A fee of **$25.00** will be charged **if you do not cancel at least 24 hours prior** to your scheduled appointment time.
- **"No-show"** appointments are billed a fee of **$40.00**
- A fee of **$25.00** will be charged for **returned checks.**
- Patients are responsible for notifying the business office of any address or insurance changes.

Signature _____ **Date** _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers.**
- **Leave messages to confirm or verify appointment information.**
- **Conduct normal healthcare operations such as quality assessments and physical therapist certifications.**

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address shown to obtain a current copy of the NOTICE OF PRIVATE PRACTICES.
We want to assure you that your medical/protected health information is secure with us.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature_____ **Date**_____