Tricare Physical Therapy

Patient Registration Form

Date: _____

Referring Physician: _____Primary Care Physician:_____

Patient Demographics:

First Name	Last Name	Date of Birth Sex Marital Status
Home Street Address	City, State, Zip Code	Social Security #
Home Phone #	Cell Phone #	Work Phone #
Home Email	Work Email	Occupation/Employer
Emergency Contact	Phone #	Relationship to Patient

Insurance Information:

Primary Insurance Company	Primary Insurance Company Phone #	Primary Policy #
Primary Policy Holder's name	Primary Policy Holder's Relationship to Patient	Primary Policy Holder's Date of Birth
Secondary Insurance Company	Secondary Insurance Company Phone #	Secondary Policy #
Secondary Policy Holder's name	Secondary Policy Holder's Relationship to Patient	Secondary Policy Holder's Date of Birth

Worker's Comp/No Fault Patients

Is your injury a worker's comp/auto accident case? If so, which carrier?	Date of Injury and State Where Injured	Body part(s) injured
Claim#	Adjuster/Case Manager Name	Adjuster/Case Manager Phone #
Attorney Name:	Attorney Phone #	Is there a Letter of Protection? (please note, Tricare does not accept LOPs)

Tricare Physical Therapy

Patient Registration Form

Are you being treated as a Direct Access patient? ☐ Yes ☐ No

(*Please note that if you are being treated through direct access (you do not have a physician's prescription), treatment can only be rendered for 30 days or 10 visits, whichever comes first. Services rendered without a physician's prescription may not be covered by your health insurance plan. By signing this form, you agree that you are financially responsible for all services not covered by your insurance through direct access treatment).*

Do you have a physician's prescription for physical therapy treatment? ☐ Yes ☐ No

(Please note that a physician's prescription for physical therapy treatment is only valid for four weeks, and that it is the patient's responsibility to acquire a new prescription to continue therapy when needed. By signing this form, you agree that you are financially responsible for services not covered in the event that you that fail to acquire an updated physician's prescription for physical therapy treatment).

Have you had any Physical/Occupational therapy this year? ☐ Yes ☐ No

If yes, when and how many visits? _____

Medicare will not pay for physical therapy services at the same time as home health care. Are you now receiving Home Health services? ☐ Yes ☐ No

Have you had Home Health services within the past 2 months? ☐ Yes ☐ No

If Yes, when were you formally discharged from Home Health? _____

Is Tricare Physical Therapy authorized to leave you reminder messages for appointments via:

Home phone? ☐ Yes ☐ No

Cell phone? ☐ Yes ☐ No

Personal Email? ☐ Yes ☐ No

Work Email? ☐ Yes ☐ No

Text message? ☐ Yes ☐ No

Preferred method of contact:_____

Is Tricare Physical Therapy authorized to leave a reminder message with a family member? ☐ Yes ☐ No

By undersigning, you acknowledge that you have read and understand this form and attest that the information you have provided above is accurate and complete.

_____ _____

Patient name (please print) **Date**

_____ _____

Patient Signature (Parent/Guardian if minor)

Tricare Physical Therapy

Patient Medical History Form

Name:_____ **Date**:_____

Major Complaint:_____ **Date of Onset of Pain:**_____

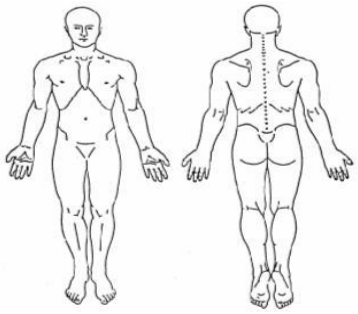
Have you had any of the following diagnostic tests done of the injured area?

MRI ☐ Yes No ☐ If yes, when and where?:_____

CT Scan: ☐ Yes No ☐ If yes, when and where?:_____

X-Ray: ☐ Yes No ☐ If yes, when and where?:_____

Indicate below where your pain is located and the level of pain you experience on a scale from 1 (low) to 10 (severe):



Past surgery(s), if any:_____

Medications/dosages you are currently taking:_____

_____

Please list any allergies that you have: _____

_____

Please check if you have had or currently have any of the following:

☐ Pacemaker	☐ Circulatory Problems	☐ Neurological Problems	☐ Heart attack
☐ Surgical/metal implants	☐ Epilepsy/Seizures	☐ Broken Bones	☐ Dizziness/Vertigo
☐ High Blood Pressure	☐ Cancer	☐ Kidney Disease	☐ Asthma
☐ Migraine Headaches	☐ Stroke	☐ Tuberculosis	☐ Osteoporosis
☐ Diabetes	☐ Irregular Heartbeat	☐ Anemia/Blood Disorders	☐ HIV/AIDS
☐ Hepatitis	☐ Other _____		

Do you smoke?_____ **Packs per day:**_____

Are you currently pregnant? Yes ☐ No ☐

By signing below, you understand and acknowledge that the above information regarding your health is accurate and complete:

_____ _____

Printed Name of Patient **Signature of Patient (or Parent/Guardian if minor)**

Tricare Physical Therapy

HIPAA Privacy Policy

****THE FOLLOWING NOTICE DETAILS HOW MEDICAL INFORMATION REGARDING YOU AS A PATIENT MAY BE DISCLOSED, AND YOUR RIGHTS AS A PATIENT TO ACCESS YOUR MEDICAL RECORDS. THIS NOTICE TAKES EFFECT JANUARY 1, 2012.****

TRICARE PHYSICAL THERAPY'S LEGAL DUTY

Tricare Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice describing our privacy practices, and adhere to the practices that are detailed herein. We retain the right to legally make changes to this notice at any time. In the event that any changes are made to this notice, the new notice will be given to you on your next visit. You may also request a copy of our HIPAA Privacy Policy at any time.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following segment details how Tricare Physical Therapy may use and disclose personal health information. However, please note that not every potential use or disclosure can be mentioned below. You may request in writing restrictions as to how Tricare may use or disclose your personal health information for reasons other than those listed below, and at any time you may revoke that authorization to stop any further disclosures.

***TREATMENT*:** Tricare Physical Therapy uses your personal health records for the primary purpose of treatment. This may include but is not limited to: consulting with and maintaining communication with your physician regarding your physical therapy treatment, contacting you regarding appointments, and providing you with information regarding treatment options or other health related benefits that may be of interest to you.

OFFICE OPERATIONS: Tricare Physical Therapy and its staff may use or disclose your health information for purposes such as performing internal administration activities, assessing our quality of care, auditing, and maintenance of medical and financial records.

PAYMENT: Tricare Physical Therapy is permitted to release to your health insurance plan any information required to facilitate in processing a claim. This may include: verifying insurance eligibility and obtaining authorization (if necessary), and obtaining payment on or appealing a claim.

***EMERGENCIES AND LAW ENFORCEMENT*:** Tricare Physical Therapy may disclose your health information in the event of an emergency. Additionally, we may release personal medical information when required by law enforcement bureaus for purposes such as police investigations.

PATIENT'S INDIVIDUAL RIGHTS

You have the legal right to request or review a copy of your health records, however the federal law requires a written confirmation in order to complete the request. You have the right to amend inaccurate or incomplete information in your medical records. If at any time you are concerned that your privacy rights have been violated, you are encouraged to submit to us a letter outlining your complaint(s). This letter may be sent to: HIPAA Privacy Officer, Tricare Physical Therapy, 460 Old Post Road, Suite 1C, Bedford, New York, 10506.

ACKNOWLEDGEMENT OF PRIVACY POLICY FORM

By undersigning, you confirm that you have received and understand Tricare Physical Therapy's HIPAA Privacy Policy.

Name (print):_____ _____ Date:_____

Signature:_____

Tricare Physical Therapy

Payment Policy Form

In-Network Insurance Plans

Patients are required to present accurate health insurance information, including providing Tricare Physical Therapy with copies of current health insurance cards, at their initial visit so that we may verify coverage. If a patient switches or loses health insurance during his or her course of treatment, he/she is required to notify Tricare Physical Therapy of the changes. Co-payments must be paid at the time of service. Patient deductibles, co-insurances, and non-covered services must be paid within 30 days of receipt of a billing statement from our office.*****Medicare patients**: Please note that Medicare has a yearly deductible and a patient responsibility of 20%. If you have any secondary insurance, we will gladly bill that company for the 20% Medicare does not cover.

Out- of -Network Insurance Plans

If a patient chooses to receive treatment at Tricare Physical Therapy under insurance with which we do not participate, our office will bill the insurance out of network. The patient will be fully responsible for all co-insurances, deductibles, and co-payments for services rendered. If a patient receives payment directly from his/her insurance carrier for services rendered at Tricare Physical Therapy, the patient shall remit payment(s) to Tricare Physical Therapy.

Self-Pay Patients

If a patient does not have insurance coverage, he/she is responsible for payment in full at the time of service. Please ask our front desk about self-pay pricing.

Worker's Compensation/No Fault Patients

In the event that a Worker's Comp/No Fault case is determined to be closed, or that benefits are denied, the patient if fully responsible for services rendered.

No-Show Policy

Tricare Physical Therapy requires 24 hour notice for the cancellation of an office visit. We reserve the right to charge a $50 fee for any office visit that is not cancelled within this time frame.

Accepted Payments

Tricare Physical Therapy accepts all major credit cards, cash, and check for payment. However, please note that Tricare reserves the right to charge a $30 returned check fee for any check that is sent back to us from our bank as not paid.

If you would like to leave a credit card on file with our office, so that we may run any co-payments, deductibles, or co-insurances on a weekly basis, please provide us with the information below:

Cardholder's name_____ Circle one: American Express MasterCard Visa Discover

Credit Card # _____ Expiration Date _____ Billing Zip Code_____

Signature_____ Date_____

By undersigning, you acknowledge that you have read and understand Tricare Physical Therapy's Payment Policy Form and accept financial responsibility for all services rendered during your course of treatment.

_____ _____ _____

Print Patient Name **Patient Signature (Parent/Guardian if minor)** **Date**