Reynolds & Associates
Physical Therapy, Inc.

NEW PATIENT REGISTRATION

ASSIGNED TO: ________ APPT DATE: _____/_____/_____

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	SEX

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )	EMPLOYMENT STATUS EMPLOYED ( ) FULL TIME STUDENT ( ) PART TIME STUDENT ( ) RETIRED ( )

E-MAIL ADDRESS (OPTIONAL) ____

IF YOU WOULD LIKE A REMINDER CALL FOR FUTURE APPOINTMENTS, WHAT NUMBER WOULD YOU LIKE US TO CALL?

PHONE #: ____ ________ NO REMINDER CALL

REFERRING PHYSICIAN INFORMATION (WHERE TO SEND TREATMENT NOTES)

PHYSICIAN	CLINIC NAME	DATE LAST SEEN

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME:	FIRST NAME:	MI

ADDRESS:	STATE	ZIP CODE

HOME PHONE	WORK PHONE
RELATIONSHIP:	

ASSIGNMENT OF BENEFITS / CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Reynolds & Associates PT, Inc. in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing, as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to, collection service fees, attorney fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of Reynolds & Associates PT Inc. as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

SIGNATURE:	**TODAY'S DATE**

Reynolds & Associates
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PATIENT INSURANCE VERIFICATION

We are happy to further extend your services by filing your primary and secondary insurances for you. As a courtesy, we pre-verified your insurance benefits (if any) and listed them below. Predetermination of benefits does not guarantee payment or coverage. Benefits are determined at the time the claim is processed. If you have any questions about the information or any uncertainty regarding your insurance coverage, please ask for assistance.

☐ According to ____________________________ (insurance carrier) you have satisfied $________________ of your $________________ (yearly) deductible. The balance of $_______________ is your responsibility to meet before any copays or co-insurance is applicable.

☐ Co-Payment: $________________ per visit or _________% per visit.

☐ Medicare will pay 80% of charges. The remaining 20% will be billed to secondary insurance or become patient responsibility.

☐ Worker's Compensation: We will bill your worker's compensation carrier for all charges. Please note that you will be financially responsible for all charges if your carrier denies coverage.

☐ Self-Pay: Balance paid in full at time of service.

If you cannot keep your appointment for any reason, please call 24 hours prior to your appointment. If you do not show or if you cancel the day of your appointment, a fee of $25 will be applied. There will also be a $25.00 charge for all returned checks. These charges will not be billed nor paid by your insurance.

PATIENT INFORMATION CONSENT

I have read and fully understand Reynolds & Associates Physical Therapy, Inc's. Notice of Information Practices. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Reynolds & Associates Physical Therapy, Inc's. Notice of Information Practices. I authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations at Reynolds & Associates Physical Therapy, Inc. I understand the identities of designated parties must be verified before the release of any information and that I retain the right to revoke this consent by notifying the Company in writing at any time.

AUTHORIZED DESIGNEE:	RELATIONSHIP:
AUTHORIZED DESIGNEE:	RELATIONSHIP:
SIGNATURE:	**TODAY'S DATE:**

Reynolds & Associates
Physical Therapy, Inc.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY.

REYNOLDS & ASSOCIATES PHYSICAL THERAPY, INC. LEGAL DUTY

Reynolds & Associates Physical Therapy, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Reynolds & Associates Physical Therapy, Inc. uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Reynolds & Associates Physical Therapy, Inc. may use your personal health related information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. We also provide information when required by law.

In any other situation, Reynolds & Associates Physical Therapy, Inc's. policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Reynolds & Associates Physical Therapy, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our facility. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Reynolds & Associates Physical Therapy, Inc. will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Reynolds & Associates Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please let the administrative staff know. You may also send a written complaint to the US Department of Health and Human Services.

EVERY PATIENT MUST RECEIVE A COPY OF THIS FORM