NORTH PENN PHYSICAL THERAPY

NEW PATIENT REGISTRATION FORM

Patient Name: ______________________ DOB: ______________

SS #: (for Tricare and Worker's Comp) ______________

Address:______________________________

City:________________State:_____Zip:________

Home phone: __________ Cell: ______________Work: ____________

Email Address: ________________________

Employer: ______________Occupation:____________________

Emergency Contact Name/Phone Number:_______________________

Referring or Family Physician / Office Location: ______________________

Date last seen by physician: _________ Next Visit Date: _________

Reason for coming to therapy: ________________

Date of Injury (or Surgery Date, if applicable):_________

Circle if you have any of the following:

High blood pressure	Pacemaker	Other heart condition ________
Diabetes	Latex Allergy	Pregnant
Cancer	Other ______________________	

List medications you are taking (provide list if available):________________

Insurance: ______________________ See Copy of Card

Subscriber Name:________________DOB:_________

Auto Accident? Y N Work Related Injury? Y N

Adjuster Name/Phone #:_______________ Claim #: ______________

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HIPAA AND FINANCIAL RESPONSIBILITY FORM

I. Notice of Privacy Practices / Patient Acknowledgement

This Notice states the uses and disclosures of my protected health information, my individual rights and the practice's legal duties with respect to my health information:

- This practice is required by law to maintain the privacy of protected health information (PHI).
- This practice is permitted to use PHI for the following purposes: treatment, payment, and communication with my other health care providers as applicable.
- Other uses and disclosures will be made only with my written authorization, and I have the right to refuse such authorization.

This practice reserves the right to change the terms of this Notice, and to make new provisions effective for all PHI that it maintains. I understand that I can obtain a copy of this document on request.

II. Financial Responsibility

NPPT will bill your insurance company on your behalf. Due to the individual nature of each plan, it is ultimately the patient's responsibility to pay those portions of treatment not covered by insurance. NPPT reserves the right to hold a credit card on file, encrypted with SSL. Patients will receive one (1) statement, then the card will be billed in full at the end of the billing cycle (30 days) unless payment arrangements have been made. Personal checks that are returned for insufficient funds are subject to an administrative fee of $35.

III. Missed Appointment Policy

There is a $50 fee for a missed appointment, billed immediately to the card on file, if you do not call 24 hours in advance to cancel or reschedule.

IV. Consent for Treatment

"I understand that I have been referred for rehabilitation treatment to North Penn Physical Therapy. NPPT will design an individual treatment plan for me, and I understand that I have the right to ask and have any questions answered prior to receiving treatment. This includes any risks or alternatives to the treatment plan that has been prescribed for me. By signing, I consent to have NPPT provide treatment under the direction prescribed by my referring physician, dentist, podiatrist and/or by my therapist.

"I have read each of the above sections. I understand and agree to the above terms and conditions."

Signature of patient / patient representative: ________________________________

Date: _________________