JAG PHYSICAL THERAPY

REGISTRATION FORM

PATIENT INFORMATION

NAME: _____
FIRST MI LAST

ADDRESS: _____
NUMBER/STREET APT. CITY STATE ZIP CODE

DATE OF BIRTH: _____ AGE: _____ GENDER: ☐ MALE ☐ FEMALE ☐ OTHER _____

SS#: _____ MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ OTHER _____

EMPLOYER: _____ OCCUPATION: _____ WORK #: _____

EMPLOYER ADDRESS: _____
NUMBER/STREET CITY STATE ZIP CODE

PREFERRED CONTACT: ☐ HOME _____ ☐ CELL _____ ☐ EMAIL _____

APPOINTMENT REMINDERS: ☐ TEXT ☐ VOICE CALL ☐ NONE

EMERGENCY CONTACT #: _____ NAME/RELATIONSHIP: _____

HOW DID YOU HEAR ABOUT US: _____

DOCTOR INFORMATION

REFERRING PHYSICIAN: _____

ADDRESS: _____
NUMBER/STREET CITY STATE ZIP CODE

PHONE NUMBER: _____ FAX NUMBER: _____

PRIMARY PHYSICIAN: _____ PHONE NUMBER: _____

Have you received Physical Therapy or Occupational Therapy treatment within the last 12 months? ☐ YES ☐ NO

Have you attended any Chiropractic, Speech Therapy or Home Care? ☐ YES ☐ NO

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

MEMBER ID #: _____ GROUP ID #: _____

Is this the Patient's insurance? ☐ YES ☐ NO If NO, who is the policy holder: _____

POLICY HOLDER DOB: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE COMPANY: _____

MEMBER ID #: _____ GROUP ID #: _____

Is this the Patient's insurance? ☐ YES ☐ NO If NO, who is the policy holder: _____

POLICY HOLDER DOB: _____ RELATIONSHIP TO PATIENT: _____

If you have a tertiary insurance please notify our office immediately

ACCIDENT INFORMATION

Auto (NF) or Workers Compensation (WC)

Is this work related? ☐ YES ☐ NO Auto accident? ☐ YES ☐ NO DATE OF ACCIDENT/INJURY: _____

WHICH STATE DID THE ACCIDENT OCCUR IN: _____ Surgery? ☐ YES ☐ NO DATE OF SURGERY: _____

ATTORNEY INFORMATION: _____
NAME FIRM

ATTORNEY ADDRESS: _____
NUMBER/STREET CITY STATE ZIP CODE

NF/WC INSURANCE CARRIER: _____

CLAIM #: _____ POLICY #: _____

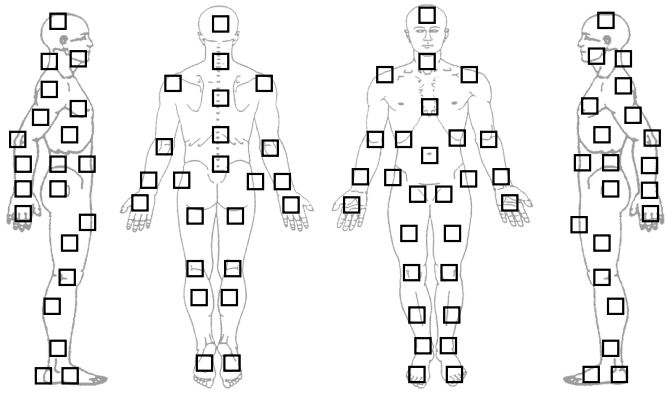
ADJUSTER NAME: _____ PHONE NUMBER: _____

ADJUSTER EMAIL: _____ FAX NUMBER: _____

Is your claim open? ☐ YES ☐ NO Is your adjuster aware you are starting therapy? ☐ YES ☐ NO

MEDICAL HISTORY

Please indicate where you have pain or other symptoms



None → *Unbearable*

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

HEIGHT: _____ WEIGHT: _____

MEDICATIONS:

Please list all over the counter and prescription medications you are currently taking. Include dosage & frequency.

_____

_____

_____

SURGICAL HISTORY:

List any surgical procedures you have had and the dates they were performed.

_____

_____

_____

DIAGNOSTIC TESTING:

Please check any diagnostic testing and/or treatments you have completed for this condition.

- ☐ MRI
- ☐ CT Scan
- ☐ Nerve Block
- ☐ Ultrasound
- ☐ X Ray
- ☐ Bone Scan
- ☐ Blood Tests
- ☐ Doppler Studies
- ☐ EMG
- ☐ Cardiac Stress Test
- ☐ Injections
- ☐ Urinalysis
- ☐ Other: _____

- ☐ Congenital Heart Defect
- ☐ Cancer
- ☐ Heart Problems/Heart Disease
- ☐ Joint Replacement/Repair
- ☐ Joint, Tendon or Muscular Pain
- ☐ Gastrointestinal Issues
- ☐ Osteoporosis
- ☐ Skin Problems
- ☐ Pacemaker
- ☐ Psychological
- ☐ High or Low Blood Pressure
- ☐ High or Low Blood Sugar
- ☐ Chest Pain/Angina/Palpitations
- ☐ High Cholesterol
- ☐ Abdominal Pain/Bloating/Gas
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Poor Balance Recent Falls
- ☐ Coughing/Wheezing or Exertion
- ☐ Dizziness/Vertigo/Fainting/Blackouts
- ☐ Gout
- ☐ Severe Headaches
- ☐ Rheumatoid Arthritis
- ☐ Prostate Problems
- ☐ Anemia
- ☐ Epilepsy/Seizure Disorders
- ☐ Ulcers
- ☐ Circulation Problems/ Blood Clots
- ☐ Depression
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Sexually Transmitted Disease/HIV/AIDS
- ☐ Tuberculosis
- ☐ Lung Disease
- ☐ Thyroid Problems
- ☐ Allergies
- ☐ Asthma/Bronchitis/Pneumonia/Chronic Cough
- ☐ Diabetes
- ☐ Stroke
- ☐ Chemical Dependency (Alcoholism)
- ☐ Latex Allergy
- ☐ Lyme Disease
- ☐ Hepatitis A, B, C
- ☐ Painful Bowels/Loose Stool/Constipation
- ☐ Multiple Sclerosis
- ☐ Depression/Anxiety/Panic Attacks

- ☐ Other: _____

Please provide details regarding the above checked conditions:

_____

_____

_____

PT/OT INITIALS: _____

PATIENT FINANCIAL RESPONSIBILITY

JAG Physical Therapy's focus is your overall health and wellness. As we continue to strive to help you meet these standards, it is important to us that you understand the terms **"Medically Necessary"**, **"Clinically Appropriate"**, **"Benefit Maximum Met"** and how this relates to your treatment.

"Medically Necessary" is defined as treatment or services that are specific to your diagnosis. When treatment is deemed medically necessary, your insurance company will reimburse JAG PT for services rendered according to physical therapy care that has a direct connection to document improved function based on our contractual agreement.

"Clinically Appropriate" or **"Benefit Maximum"**: Insurance companies may deny care despite treatment that continues to manage, reduce or eliminate your pain. This may be "clinically appropriate" for your circumstances but may not be considered "medically necessary" by your insurance carrier. Benefit Maximum is defined as a specific number of physical therapy visits allowed by your insurance policy during a specific time frame. Most treatments reach a point where no further improvement can be expected. This is called the point of maximum therapeutic benefit (MTB). MTB can be reached when complaints either fully resolve, or when pain and/or disability persist – even with ongoing treatment.

"Denials/Appeals": It is a patient's responsibility to initiate an appeal with the insurance provider when services are denied.

JAG Physical Therapy will provide the necessary clinical information upon request.

If your insurance company determines that services are no longer medically necessary, you will be billed $100.00 per visit for services that have been rendered.

I understand it is my responsibility to confirm my coverage with my insurance carrier and that JAG Physical Therapy may verify such coverage as a courtesy to me. JAG PT will not be held responsible or liable for inaccurate information or denials provided by your insurance carrier after services have been rendered.

My signature below acknowledges that I have read and fully understand that:

1. JAG Physical Therapy has discussed medical necessity limitations, clinically appropriate care, and specific number of office visits allowed per my insurance company.
2. I have been informed of my financial responsibility if my insurance company denies all or part of these services as not medically necessary.
3. I fully accept the financial responsibility to pay for denied services at the time my insurance carrier deems my treatment not medically necessary.
4. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier.

PATIENT NAME: _____ DATE: _____

PATIENT SIGNATURE: _____

CONSENTS AND DISCLOSURES

(I) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS

Ordinarily, discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

_____ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent to JAG Physical Therapy office staff to discuss my medical condition or billing concerns with the person/persons I have designated below.

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

(II) CONSENT TO RELEASE INFORMATION TO A TELEPHONE ANSWERING MACHINE

In an effort to protect your confidentiality, medical history and appointment reminder specifics (including date & time) will not be left on your answering machine, email and/or received in a text message; however, if you prefer us to do this, we can with your consent. Please understand that you are waiving your right of confidentiality if you give your permission.

_____ INITIAL HERE TO GIVE CONSENT

I am hereby giving my consent for the JAG Physical Therapy office staff to leave medical history or appointment reminders (including date & time) on my telephone answering machine, email and/or text message.

_____ INITIAL HERE TO DECLINE CONSENT

(III) PATIENT AUTHORIZATION TO TREAT AND SUBMIT MEDICAL CLAIMS

I authorize payment to JAG Physical Therapy, LLC for all physical therapy services rendered. I also understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

I consent to be assessed by and to receive treatment from JAG Physical Therapy, LLC consistent with a plan of care. I confirm that I have been informed and have participated in planning the care and procedure(s) to be carried out by JAG Physical Therapy LLC and sign this consent willingly and voluntarily.

I consent to the release of information and/ or disclosure to JAG Physical Therapy, LLC of all or any part of my medical record to other health care providers involved in my care or third-party payers as is necessary for processing claims.

I am aware my child is receiving Physical/Occupational Therapy at JAG Physical Therapy. I am unable to attend his/her office visits. Please accept this form as my consent to treat my child.

PARENT/ GUARDIAN INITIALS IF APPLICABLE: _____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENTS AND DISCLOSURES.

PATIENT SIGNATURE: _____ DATE: _____

PARENTAL SIGNATURE FOR MINOR: _____ DATE: _____

ATTENTION

JAG PHYSICAL THERAPY NO SHOW/CANCELLATION POLICY

As a courtesy to other patients, as well as the JAG Physical Therapy staff, we would appreciate a call of notification to cancel appointments at least 24 hours prior to your scheduled appointment. Please make sure to reschedule your appointment after canceling. If a no call is received/documented your visit will be counted as a "**NO SHOW**."

In reference to missing or not showing to your scheduled appointment without prior notification, a fee of $35 will be collected upon your next visit. Hopefully, this policy will ensure better scheduling availability as to not block appointments for other patients. Should there be any misunderstandings or miscommunications regarding your scheduled appointment, please speak to our office manager.

REFERRALS

PLEASE CHECK IF YOUR INSURANCE CARRIER REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN.

REFERRALS ARE PATIENT RESPONSIBILITY AND MUST BE COMPLETED AND TURNED IN TO JAG PHYSICAL THERAPY ON TIME TO AVOID ANY INSURANCE DENIALS.

VERIFICATION OF BENEFITS

JAG Physical Therapy verifies patient benefits with your insurance carrier as a courtesy to the patient. Benefits quoted are not a guarantee of payment. Patient is ultimately responsible for any denied services rendered at JAG Physical Therapy.

DIRECT ACCESS PATIENTS ONLY

UNDER DIRECT ACCESS, THE PATIENT CAN BE TREATED FOR 10 VISITS OR 30 DAYS WITHOUT REFERRAL FROM A PHYSICIAN.

We are required to inform the patient that the patient's health plan or insurer might not cover treatment without referral. In addition, we inform the patient that services might be covered by their health plan or insurer with a referral. We will verify health benefits at the time of visit and inform the patient of their physical therapy benefits. Benefits are not a guarantee of payment.

IF THE PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR GUARDIAN MUST SIGN THIS FORM.

I, _____ have read the above and understand that I may be billed for the services if denied by my heath plan or insurer.

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WORKERS COMPENSATION & NO-FAULT PATIENTS ONLY - NOTIFICATION OF AGREEMENT (IME)

Patients are responsible to inform the front office of their scheduled Independent Medical Exam (IME) with their insurance carrier. These exams determine whether you will be able to continue treatment under your case benefits. You, the patient, along with your physician will receive a determination letter 7-10 days after the exam. The patient is responsible for providing JAG Physical Therapy a copy of the determination.

Treatment performed while awaiting the exam results can be denied if the determination is returned with a negative result. In this event the financial responsibility becomes the patient's, if you choose to receive treatment on the IME scheduled date or the days following before receiving a determination.

If you should have any questions pertaining to your responsibilities as a Workers Compensation or No-Fault patient, please feel free to speak with the Office Manager at your treating facility.

I, _____ the patient understands by signing this form I accept the responsibility of notification and appointment scheduling based on the requirements of my case.

PATIENT SIGNATURE: _____ DATE: _____

PATIENT BILL OF RIGHTS

JAG Physical Therapy strives to ensure that each patient is provided the highest quality of care in accordance with high professional standards that are continually maintained and reviewed. We understand that patients have entrusted their care to us and we treat all patients with dignity, respect, and only provide appropriate services as needed. By requiring informed consent for treatment, we assure that each patient and/or his/her representative is involved in aspects of a treatment plan. Patients and their representatives are afforded consideration of their privacy concerning their own medical care program. Case discussion, consultation, examination and treatment are considered confidential and should be conducted discretely. The patient has the right to full information in layman's terms concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. We will endeavor to involve patients in their treatment program by incorporating their feeling, interest, attitudes and goals in the treatment planning and implementation process. A patient has the right to physical therapy services without discrimination based upon race, color, religion, sex, sexual preference or national origin.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE PATIENT BILL OF RIGHTS.

PATIENT SIGNATURE: _____ DATE: _____

PARENTAL SIGNATURE FOR MINOR: _____ DATE: _____