PATIENT REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name:	First:	MI:	❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	Social Security #:	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street Address:	Cell Phone #:	Home Phone #:

P.O. Box #:	City:	State:	ZIP Code:

Employer:	Employer Address:	Employer Phone #:

Email (For Complimentary Appointment Reminders):

Have you been previously treated here: No ❑ Yes ❑ If so, when: _________________

Chose NPT because/Referred to NPT by:

❑ Dr. _______________________ ❑ Internet ❑ Hospital ❑ Family/Friend ❑ Radio/Newspaper ❑ Phonebook ❑ Other: ___________

INSURANCE INFORMATION

(Please provide a copy of your insurance card to our staff.)

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Primary Insurance:	Policy #:	Group #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of Secondary Insurance (if applicable):	Policy #:	Group #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Person/Company Responsible for Bill:	Birth Date: / /	Address (if different from above):	PO Box #: ( )

City:	State:	Zip Code:	Social Security #: ( )

Are you being represented by an attorney? ❑ Yes ❑ No If yes, Attorney Name: __________________ Phone #: _____________

IN CASE OF EMERGENCY

Name of Local Friend or Relative:	Relationship to Patient:	Cell Phone #:	Home/Work Phone #:

REFERRAL INFORMATION

Referring Physician (address & phone, if known):

Describe the reason you are here: **Date of Symptom Onset /Injury:**

Date of Surgery (if applicable): **Date of next visit with Referring Physician (if applicable):**

MEDICAL HISTORY INFORMATION

Is the reason for therapy accident related? ❑ **Yes** ❑ **No**

If yes, please check one: ❑ **Accident** ❑ **Auto** ❑ **Work** ❑ **Other** **If Other, please explain:**

Are you currently receiving any other care for the condition mentioned above? ❑ **Yes** ❑ **No** **If yes, explain: _______________**

Have you ever received therapy in the past for the condition mentioned above? ❑ **Yes** ❑ **No**

Have you received therapy services for other problems/conditions during this calendar year? ❑ **Yes** ❑ **No**

If yes, explain:

Current Medications (Prescription & Over the Counter): If you have a list, we would be happy to photocopy it for you.

Allergies:

Previous surgeries or other conditions for which you have been hospitalized, including the approximate date:

Do you now have or have you ever had any of the following conditions? (check all that apply)

❑ Difficulty Swallowing	❑ Motion Sickness	❑ Stroke	❑ Arthritis	❑ Epilepsy/Seizure
❑ Fever/Chills/Sweats	❑ Anemia	❑ Diabetes	❑ Fibromyalgia	❑ Osteoporosis/Osteopenia
❑ High Blood Pressure	❑ Blood Clots	❑ Hepatitis	❑ Pregnancy	❑ Depression
❑ Heart Trouble	❑ Pacemaker/Defibrillator	❑ Pain	❑ Cancer	❑ Swelling/Edema
❑ Unexplained Weight Loss	❑ Shortness of Breath	❑ HIV	❑ Headaches	❑ History of Drug Abuse
❑ Joint Replacement(s)	❑ Multiple Sclerosis	❑ Constipation	❑ Neuropathy	❑ Dizziness/Vertigo
❑ Parkinson's Disease	❑ Other: ______________________________			

Do you have trouble performing or are you unable to perform any of these tasks? (check all that apply)

❑ Getting into/out of bed ❑ Eating ❑ Getting into/out of chair ❑ Sitting ❑ Writing

❑ Walking up/down stairs ❑ Walking ❑ Work related activities ❑ Standing ❑ Dressing

❑ Bathing/Showering ❑ Doing Laundry ❑ Vacuuming ❑ Cooking ❑ Shopping

❑ Getting into/out of shower ❑ Cleaning ❑ Brushing your teeth ❑ Sleeping

❑ Getting into/out of car ❑ Driving ❑ Personal Hygiene activities ❑ Other: ________________________

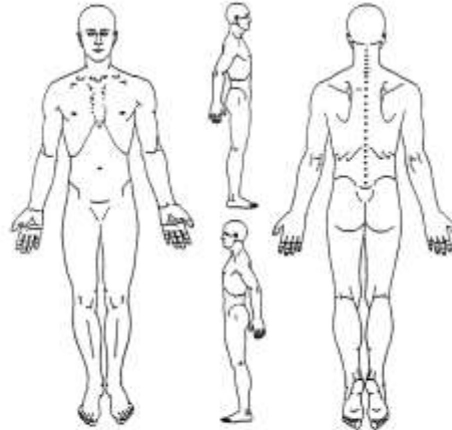
If you are having pain, please rate your current pain. (Circle the number on the pain scale.)

Describe your pain (check all that apply): ❑ Pins & Needles ❑ Stabbing ❑ Burning ❑ Aching ❑ Other _________

What makes your pain worse:

What makes your pain better:

Where is your pain? (Mark the area(s) on the body diagram.)



OPTAVIA HEALTH GOAL QUESTIONNAIRE

I'm currently interested in the following areas . (Check all that apply.)

❑ Losing weight ❑ Learning more about exercise programs ❑ Decreasing need for medication

❑ Improving nutrition ❑ Improving quality of sleep ❑ Increasing energy levels

❑ Learning techniques to develop healthy habits ❑ Understanding my heath numbers

Are you interested in a complimentary Health Coaching Session with one our personal health coaches to discuss your health goals and develop a personalized action plan? ❑ Yes ❑ No

If yes, what day(s) and time(s) during the week work best for you? (Circle all that apply.)

Monday Tuesday Wednesday Thursday Friday

7 AM – 10 AM 10 AM – 1 PM 1 PM – 4 PM 4 PM – 7 PM

What is the best phone number to contact you? ____________________________

Email Address: ____

BRAINYEX (ONLY FILL OUT IF YOU ARE A BRAINYEX PARTCIPANT.)

Your Weight: _________________ **Your Height:** ________________

Current Exercise Days/Level: ____

Preferred Mode of Exercise: ____

Do you consent to us contacting your primary care physician (PCP) during your participation in BrainyEX? ❑ **Yes** ❑ **No**

Do you have any concerns about starting an exercise program? ❑ **Yes** ❑ **No** **If yes, explain:** ______________________________

Do you have any concerns about your cognitive functioning? ❑ **Yes** ❑ **No** **If yes, explain:** _______________________________

AUTHORIZATION / CONSENT / FINANCIAL POLICY

Today's Date:________________

PATIENT INFORMATION (please print)

(NAME) Last:_____________ **First**:_______________________ **Middle**:_______ Birth Date:___/___/_____

THANK YOU FOR CHOOSING NICHOLSON PHYSICAL THERAPY, PLC!

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST CARE POSSIBLE. YOUR CLEAR UNDERSTANDING OF OUR POLICIES IS VERY IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT ANY OF OUR POLICIES OR YOUR RESPONSIBILITIES.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have refused a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 712-213-8184, or by requesting one at this office.

CONSENT TO MEDICAL TREATMENT

I am presenting for outpatient physical therapy care at Nicholson Physical Therapy, PLC (NPT). I give my consent for physical therapy evaluation and treatments to be performed by NPT. Treatments will be administered under the direction of my physician (if applicable) and a therapist licensed by the State of Iowa. I understand no guarantees have been made regarding the outcome of this treatment.

SCHEDULING AND MISSED APPOINTMENTS

It is the patient's responsibility to make and confirm their appointments (date and time), and to be on time to allow sufficient treatment for themselves and the next scheduled patient. Nicholson Physical Therapy, PLC (NPT) requires 24 hours notice of appointment cancellation for general appointments. Appointments missed and those not previously cancelled will be charged a cancellation/no show fee of $25.00. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

FINANCIAL POLICY

Insurance

We need complete and accurate information about your policy. We must obtain a copy of your driver’s license or valid photo I.D. and current valid insurance to provide proof of insurance. This would include both primary and secondary insurances. If you fail to provide us with the correct insurance information, you will be responsible for the balance of a claim. Knowing your insurance benefits is your responsibility. As a courtesy, Nicholson Physical Therapy, PLC (NPT) will call the provided insurance company to verify eligibility and benefits. However, this will not be a guarantee of eligibility and benefits. Please contact your insurance company with any questions you have regarding your coverage.

In-Network

You are responsible for meeting the in-network deductible before your insurance will pay for services rendered. You are responsible for co-payments/coinsurance/deductible payment as specified in your “Schedule of Benefits.” NPT has agreed with your insurance company to accept the Preferred Provider maximum allowable charge as full payment of the services rendered. You are responsible to pay for any services that are received but not covered under your policy. **Co-payments, coinsurance, or deductible payments are due at the time of service.**

Out-of-Network

You are responsible for meeting the out-of-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments/coinsurance/deductible payment. You are also responsible for the difference between billed charges and your insurance company's maximum allowable charges. Your out-of-network benefits for outpatient physical therapy should be explained in your insurance policy's "Schedule of Benefits." **Co-payments, coinsurance or deductible payments are due at the time of service.**

Uninsured Patients

Fee-for-service is exclusively a non-insurance financial arrangement. The fee-for-service arrangement is exclusively separate from the In-Network and Out-of-Network scenarios. Fee-for-service receipts cannot be submitted for insurance for reimbursement. NPT will charge Wellmark Blue Cross Blue Shield reimbursement rates for services rendered. **Payment is due in full at the time of each visit.**

Work Compensation, Personal Injury, Auto or Involvement of an Attorney

You must still provide us with a copy of your personal insurance card. We may also need a physician's referral for these cases. In the event your claims are denied by the liability carrier or that the personal injury protection benefits are exhausted, we will file claims with your personal health insurance policy. If your personal insurance policy denies the claim for any reason, you are responsible for the full payment of your bill. NPT is not able to carry service balances due to delays in processing claims or litigation. Please be advised that full payment of each service will be due after 90 days of that service.

Non-covered services

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. Also, most insurance companies do not pay for medical supplies (such as exercise equipment, braces and/or therapeutic supplies) **You must pay for these services in full at the time of each visit.**

Minors

A parent or legal guardian must accompany the minor patient at the time of initial visit. The parent or legal guardian is responsible for full payment as outlined in this financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Claims Submissions

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim**. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Coverage Changes

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Payment Period

All accounts must be paid in full within 3 months of your first date of service. Failure to pay within that time period will result in turning your account over to a collection agency regardless of payments.

Nonpayment

If your account is over 60 days past due with nonpayment, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. You are responsible to pay all charges associated with the cost of collection if your account becomes delinquent, including: monthly service charges, interest, collection fees, court costs and attorney's fees on the account until paid in full.

Payment Options

We accept Visa, Mastercard, Discover, checks and cash. All returned checks are subject to a $25 service charge. Accounts with two returned checks will no longer have the option of paying by check.

Refunds

Overpayments are refunded to the appropriate party, normally the insurance company or the guarantor. Patient refunds will not be processed until all active or past due accounts are paid in full.

I CERTIFY THAT I HAVE READ AND UNDERSTAND FULLY THE ABOVE INFORMATION

____ ________________

Patient or Responsible Party Signature Date

____ ________________

Staff Signature Date

Effective May1, 2017