

Previous Patient? Y / N \_\_\_\_\_ Date: \_\_\_\_\_  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Ailment \_\_\_\_\_  
 Telephone: Home (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Work (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Would you like to receive appointment reminders by E-mail? Y / N \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
 Emergency Contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ PCP \_\_\_\_\_  
 How Did You Hear About Us? ( ) Ad ( ) sign ( ) doctor ( ) ins. Co. ( ) website ( ) friend \_\_\_\_\_  
 Appt time needed: \_\_\_\_\_ Flexible? Y / N \_\_\_\_\_  
 Insurance: ( ) BC/BS ( ) Medicare ( ) Auto ( ) WC ( ) Other \_\_\_\_\_  
 Do you have secondary insurance? ( ) Yes ( ) No \_\_\_\_\_

**EMPLOYER INFORMATION**

Employer Name \_\_\_\_\_  
 Work Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Job Title \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Who is the Insured?: Self ( ) Spouse ( ) Parent ( ) Other ( )  
 Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I acknowledge that the information stated above is true. I authorize that payment of any insurance benefits for health care services or goods may be made directly to *Purcellville Orthopedic Physical Therapy*. I also acknowledge by signing below I hereby accept the terms and agreements made by the attached *Purcellville Orthopedic Physical Therapy-Patient Registration and Consent for Medical Treatment Form*.

\_\_\_\_\_  
 Patient/Responsible Party Signature Relationship Date

PATIENT NAME: \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION/VERIFICATION**

( ) Workers Compensation ( ) Auto/No Fault ( ) Medicare ( ) BC/BS ( ) Commercial ( ) Other

Date of Injury \_\_\_\_\_ Was injury related to accident? ( ) Yes ( ) No

Insurance Company \_\_\_\_\_

Policy/Claim # \_\_\_\_\_ Group # \_\_\_\_\_

Case Manager \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Effective Date \_\_\_\_\_ Maximum # of Visits \_\_\_\_\_ / \_\_\_\_\_

**PRECERT REQUIRED** ( ) Yes ( ) No **REFERRAL REQUIRED** ( ) Yes ( ) No

% Coverage \_\_\_\_\_ Co-Pay \_\_\_\_\_ In Network \_\_\_\_\_ Out of Network \_\_\_\_\_

Deductible \_\_\_\_\_ Amount Met \_\_\_\_\_ Out of Pocket \_\_\_\_\_

Authorization # \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Comments \_\_\_\_\_

Spoke with \_\_\_\_\_ Date \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION/VERIFICATION**

( ) Auto/No Fault ( ) Medicare ( ) BC/BS ( ) Commercial ( ) Other

Date of Injury \_\_\_\_\_ Was injury related to accident? ( ) Yes ( ) No

Insurance Company \_\_\_\_\_

Policy/Claim # \_\_\_\_\_ Group # \_\_\_\_\_

Case Manager \_\_\_\_\_

Insurance Billing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Effective Date \_\_\_\_\_ Maximum # of Visits \_\_\_\_\_ / \_\_\_\_\_

**PRECERT REQUIRED** ( ) Yes ( ) No **REFERRAL REQUIRED** ( ) Yes ( ) No

% Coverage \_\_\_\_\_ Co-Pay \_\_\_\_\_ In Network \_\_\_\_\_ Out of Network \_\_\_\_\_

Deductible \_\_\_\_\_ Amount Met \_\_\_\_\_ Out of Pocket \_\_\_\_\_

Authorization # \_\_\_\_\_ Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Comments \_\_\_\_\_

Spoke with \_\_\_\_\_ Date \_\_\_\_\_

**Purcellville Orthopedic Physical Therapy**  
125 Hirst Road  
Suite 6A  
Purcellville, VA 20132  
540-751-1970, fax 540-751-1971

**Patient Registration and Consent for Medical Treatment**

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Purcellville Orthopedic Physical Therapy.
2. **Authorization for Release or Information:** Purcellville Orthopedic Physical Therapy may release information from my medical records to any health care provider involved in my care and treatment. Purcellville Orthopedic Physical Therapy may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Purcellville Orthopedic Physical Therapy is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Purcellville Orthopedic Physical Therapy, *which are not paid*, by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from Purcellville Orthopedic Physical Therapy, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Purcellville Orthopedic Physical Therapy. I understand that I am responsible for a \$25.00 returned check fee in addition to any other associated bank charges.
4. **Preauthorization Requirements:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Purcellville Orthopedic Physical Therapy charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Purcellville Orthopedic Physical Therapy charges not paid.
6. **Charge for No Show/Cancellation without 24-hour notice:** I understand that 24-hour notice is required for canceling an appointment, and I will be charged a \$25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

**I acknowledge that:**

- I have read this form and understand its contents.
- I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
- I am responsible for all payments and/or co-payments that are due at the time of service.
- I have received a copy of Purcellville Orthopedic Physical Therapy HIPAA Policy.

\_\_\_\_\_  
Signature of Patient or Legally Responsible Person

\_\_\_\_\_  
Name (PRINT)

\_\_\_\_\_  
Relationship/Reason Why Patient is Unable to Sign

\_\_\_\_\_  
Date

**INSURANCE WAIVER**

**I understand that if Purcellville Orthopedic Physical Therapy is not an in-network participating provider for my insurance company. I agree to pay all charges and will submit on my own for reimbursement of any charges from my insurance company.**

\_\_\_\_\_  
**Signature of Patient or Legally Responsible Person**

\_\_\_\_\_  
**Name (PRINT)**

\_\_\_\_\_  
**Relationship/Reason Why Patient is Unable to Sign**

\_\_\_\_\_  
**Date**