NEW PATIENT REGISTRATION FORM
Please print

Patient Information

Patient Name: (Last, First, MI)____DOB:____/____/_____

Home address: ____

Mailing address: (if diff)______________________________Email Address:________________________

Home Phone: (   )   -   Cell Phone: (   )   -   Work Phone: (   )   -

Employer:_______________ Employer Phone: (   )   -   Occupation: _______________

Gender: M / F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Retired ☐ Student

Spouse Name: ___________ Spouse Employer _______________ Spouse phone: (   )   -

Emergency Contact:___________________________ Phone Number: (   )   -

Referring Physician:____________________________ Date of Next Appointment:_____________

Appointment Reminder (circle as many): call / text / email / none Carrier if text: _____________

Billing Statements for remainder of deductibles, copays or coinsurance (circle one): email (.pdf) / mail

Note: If there is an issue, insurance EOB's may not be received back for 6-12 weeks or more. We appreciate your patience.

Insurance Information

PRIMARY Insurance: ________________________________Policy Holder Name:________________

DOB:___/___/___________SSN:_____-_____-__________ Relationship: __________________

Policy Holder address (if different from above):____

Policy ID#:___________________________________ Group #:________________

SECONDARY Insurance:_____________________________________ (if policy holder is different add info on back)

Policy ID#:___________________________________ Group #:________________

Treatment Information

Cause of Injury (circle one): Illness / Injury / Work Related / Auto Accident Approx. Date: ___/____/____

Auto Accidents only Adjuster name:________________________Adjuster phone: ____________
Name of insured:______________________Lawyer and phone:__________________________________

I acknowledge that the above information is correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I understand that regardless of my insurance status, I am responsible for the balance of my account.

SIGNATURE:_______________________________________Date: ____/____/_____

NEW PATIENT REGISTRATION FORM
Please print

PAST MEDICAL HISTORY QUESTIONNAIRE

Name: ____ HT: ________ WT: ________

Reason for Therapy: ____

____

Date of Injury: ____________________ Date of Surgery: ____________________

Have you ever received therapy for the above-mentioned condition? ☐ Yes ☐ No

If so, when: ____________________ Treatment Received: ______________________________

Was the treatment received successful? ☐ Yes ☐ No *Could you be or are you pregnant?* ☐ Yes ☐ No

Do you now or have you ever had any of the following:

Hepatitis	Yes	No	Diabetes	Yes	No
Thyroid Problems	Yes	No	Hernia	Yes	No
Arthritis	Yes	No	Anemia	Yes	No
Osteoporosis	Yes	No	Hypersensitivity to Hot/Cold	Yes	No
High Blood Pressure	Yes	No	Swelling in Ankles	Yes	No
Heart Disease	Yes	No	Deep Vein Thrombosis (DVT)	Yes	No
Heart Attack	Yes	No	Seizures/Epilepsy	Yes	No
Pacemaker	Yes	No	Metal/Surgical Implants	Yes	No
Vascular Disease	Yes	No	Cancer/Tumor	Yes	No
Stroke	Yes	No	Recent Weight Loss or Gain	Yes	No
Asthma	Yes	No	Current Infections	Yes	No
Shortness of Breath	Yes	No	Kidney/Bladder Problems	Yes	No
Urinary Incontinence	Yes	No	Fecal Incontinence	Yes	No
Pelvic Pain	Yes	No	Fibromyalgia	Yes	No
Chronic Cough	Yes	No	Substance Abuse	Yes	No
Fainting Spells	Yes	No	Head Injury/Concussion	Yes	No
Previous Fractures	Yes	No	Tuberculosis	Yes	No
Hearing Loss	Yes	No	Depression	Yes	No
Anxiety	Yes	No	Previous Surgeries	Yes	No
Other	Yes	No			

If you answered "yes" to any of the above, please explain and give the approximate date(s):

____

____

____

Do you have any allergies? ☐Yes ☐No List allergies: ______________________________

Are you presently taking any medications? ☐ Yes ☐ No

If yes, please list medications (Include Dosage, Route, #Times Daily): ______________________

____

The above information is correct to the best of my knowledge.

SIGNATURE of patient/parent/guardian**:** ______________________________ Date: ____/____/_____

NEW PATIENT REGISTRATION FORM
Please print

Consent for Treatment of Minors

Anderson Physical Therapy Associates requires that a parent or legal guardian accompany any minor child (under 18 years of age) to their initial physical therapy evaluation. It is encouraged that the parent or legal guardian accompany the minor patient to his or her physical therapy appointments. In the event that a parent or legal guardian is unable to accompany a minor child to a medical appointment, the parent or legal guardian must sign this consent for treatment of the minor to allow treatment without parent present. This consent will be kept on file throughout the duration of the patient's course of treatment at Anderson Physical Therapy Associates.

Name of child____

Name of parent or legal guardian____

Address of parent or legal guardian____

Telephone number of parent or legal guardian____________________________________

I give Anderson Physical Therapy Associates permission to treat my child listed above without a parent or legal guardian being present.

SIGNATURE of patient/parent/guardian**:**___________________________Date: ___/___/____

NEW PATIENT REGISTRATION FORM
Please print

Consent for Treatment

I, the undersigned, voluntarily consent to the use or disclosure of my protected health information by Anderson Physical Therapy, Inc. (hereby known as "Anderson") for the express purpose of providing treatment, obtaining payment for my health care costs or to conduct health care operations. I understand that treatment may be conditional upon my consent.

I understand that I have the right to request a restriction as to how my protected health information is utilized or disclosed in order to carry out treatment, receive payment or other health care operations of the clinic. Anderson is not obligated to agree to my stated restrictions. I understand that should Anderson agree to my stated restrictions that it will be binding Anderson and my physical therapist. I have the right to revoke this consent in writing, at any time, except to the extent that my physical therapist and Anderson have taken action in reliance on this consent.

My protected health information consists of any health information, including my demographic information, collected from me and created or received by my physical therapist, other health care providers, a health plan, my employer, or a health care clearinghouse. This protected health information may relate to my past, present or future physical or mental health or any other condition that identifies me, or when there is a reasonable basis to believe the information may identify me.

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I have been shown where the Notice of Privacy Practices is physically posted prior to signing this Consent for Treatment and may request a copy at any time or download it from www.andersonpt.biz. This notice describes the variety of uses and disclosures of my protected health information that may occur during my treatment with Anderson. The notice also outlines my rights and responsibilities with respect to my protected health information. I understand that Anderson has the right to alter their Notice of Privacy Practices at any time. If changes are made to the policy, Anderson will post a written notification in its offices.

I hereby authorize Anderson to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance directly to me and that I am responsible for the payment.

I hereby authorize the insurance company/insurance administrator to pay by check or electronic funds transfer (EFT) and for it to be mailed directly to Anderson the expensive benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner, any balance of professional charges.

I direct my attorney to pay any outstanding expenses from my settlement, and in effect, protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the physical therapist's additional protection and consideration for his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover. I have been advised that if my attorney does not wish to cooperate in protecting this physical therapist's interest, the physical therapist will not await payment, but require me to make payment on a current basis. I authorize Anderson to administer care as deemed appropriate and necessary to myself or to ________________________________, my dependent.

SIGNATURE of patient/parent/guardian**:**___________________________________Date: ____/____/_____

NEW PATIENT REGISTRATION FORM
Please print

Physical Therapy Anderson Associates

Cancellation Policy

Your appointment time will be scheduled exclusively for you and to best accommodate your schedule. It is our practice not to schedule multiple patients on your therapist during your appointment. To continue this business practice so you can receive one-on-one care we please ask that you provide a 24-hour notice at minimum if you need to reschedule an appointment.

Please notify us by calling our office at 678-866-4104 and leave a voicemail. If necessary, email notifications to:

carecoordinatorbraselton@andersonpt.biz OR carecoordinatorgainesville@andersonpt.biz.

A fee of $35 may be charged for a second cancelled appointment and any subsequent cancellations. In the case of emergency situations or personal illnesses you will not be charged. A cancellation fee is not billable to your insurance provider and is your responsibility.

When other patients do cancel appointments at the last minute or a therapist's schedule must be rearranged we may contact you to see if you would be able to adjust your appointment time. In that case, we would greatly appreciate your flexibility.

If we are billing a workers' compensation carrier or motor vehicle insurance provider for an existing claim, you cannot be assessed a cancellation fee for missed appointments. Please be advised that we may elect to discontinue your treatment after two missed appointments for those who do not adhere to our policy.

Your time is precious and we will make every effort to accommodate your schedule. We ask for the same courtesy and will do our best to make sure that we run on time and make your appointment specific to you and your needs.

SIGNATURE of patient/parent/guardian**:**__________________________________Date: ____/____/_____

NEW PATIENT REGISTRATION FORM

Please print

Financial Policy

Welcome to Anderson Physical Therapy Associates! The below information outlines all aspects of the financial responsibility associated with your treatments. Please read carefully and sign where indicated. A copy of this form will be issued to you upon request.

Insurance Plans

Anderson partners with most national and regional insurance plans. If we are considered out of network with your insurance carrier, payment in full will be expected at each visit.

Patients are encouraged to contact their insurance provider for verification or clarification of allowed benefits. Knowing your insurance benefits is your responsibility. Anderson bills your provider and any account balance incurred is legally your responsibility. The adult, parent or legal guardian accompanying a minor dependent is financially responsible for all services rendered by Anderson and agree to all terms listed herein.

If Anderson will be billing a workers' compensation carrier or motor vehicle insurance provider it is imperative that we receive your claim information as quickly as possible. We will also require a copy of your personal insurance information in the event that your workers' compensation or motor vehicle accident claim is denied.

Delinquent Accounts

Delinquent accounts will be charged 1.5% of the past due balance each month (18% per year) after 90 days. If an account is sent to a collection agency the account will additionally be charged the 30% collection fee, any attorney's fees and court costs.

Terms of Agreement

I, the undersigned, hereby agree with the following:

- Co-pays and deductibles must be paid at the time of service per contract with the insurance company.
- I understand that I am financially responsible for all charges assigned as my responsibility per my insurance company explanation of benefits.
- I will present a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify Anderson of any changes in my information, including but not limited to, address, phone number or insurance coverage.
- My insurance company may need for me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.
- I certify that I (or my dependent) have insurance coverage as provided to Anderson and assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by insurance provider. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand that I may be assessed a charge of $35 for missed appointments not cancelled within 24 hours of my scheduled appointment time. These charges are not covered by insurance.

SIGNATURE of patient/parent/guardian**:**_________________________________Date: ____/____/_____