Patient Registration and Assignment of Benefits

**PATIENT IDENTITY CHECK* PICTURE ID__ ADDRESS__ INSURANCE CARD__ OTHER_____________ VERIFIED BY_______*

Patient
Name: First______________________________ Middle______________________ Last____________________________________

If the patient is a minor: Parent(s) or Legal Guardian(s) Name____

Mailing
Address____City_________________________ST_____ZIP____________

Patient SS# _____________-_______________-_____________ Guardian SS#______________-______________-_____________

Hm.Ph.# ________________________ Cell / Pager___________________________ other___________________________________
Patient
Date of Birth: __________/__________/________ Gender : M / F Retired?: Y or N Student?: Y or N Employed?: Y or N

Employer____

Employer Ph. #___________________________________Ext__________ Contact Nm.__________________________________

In case of an Emergency please contact ____

Hm. PH____________________________ ***Wk. PH*** ___________________________ ***Cell PH*** _________________________

► PRO PRIVACY POLICY - HIPAA PRO Physical Therapy, LLC, maintains compliance with (HIPAA) the Health Insurance Portability and Accountability Act of 1996 privacy regulations that passed into law on December 20, 2003. We obtain your voluntary consent to provide treatment and to release medical records to the appropriate entities that you designate to provide health care treatment, and or payment. The PRO staff both licensed and clerical use patient information to ensure quality care, appropriate billing and reimbursement for services. You may correct, amend, access, and request a copy of your medical record and history by signing a letter of Medical Release for the information. The cost for copies of medical records is in accordance with Virginia State law. We protect all patient information within the guidelines provided by, federal, state, and local government. If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 540-636-6179. I have read the above and been offered a policy copy.

Sign and Date to acknowledge HIPAA (sign-_____________________________________ date_________________

► CONSENT FOR CARE AND TREATMENT By signing below, I hereby agree and give my consent for the staff of P.R.O. Physical Therapy to administer medical care and treatment that is considered necessary for my physical and medical condition.
Sign and Date for Consent (sign-_______________________________________date______________________

►CONTINUE TO PAGE 2

Name_____________________________________ **W/C Date of Injury** ____/_____/_____

***Comp Carrier and Claims Address** ____

____

Claim #_____________________________________

PRIMARY INS to be filed ____ **Card Scanned** ______

SECONDARY INS to be filed ____ **Card Scanned** ______

TERTIARY INS (if applicable to be filed ____ **Card Scanned** _______

Coverage Notes____

____

____

If required, authorization will be obtained. PRO contacts your insurance company as a courtesy to you. Every patient is encouraged to understand their individual coverage by directly communicating policy questions to their insurance company.

COPAY due at Each Session____________ ***Coinsurance % per Session*** ___________

Plan Deductible _____________***Amount Met @ time of Call*** _____________

By signature below, I hereby assign all medical benefits to which I am entitled to PRO Physical Therapy for services rendered. I authorize PRO Physical Therapy to release all information necessary, including medical records, to assist in securing payment for said services. A copy of this assignment is to be considered as valid as original.

Furthermore, by signing below I understand that the benefit information written or quoted is not a guarantee of payment for services and in no way releases me from any responsibility regarding any and all unpaid balances on my or my dependents account, as it applies to the care, goods and services rendered by PRO Physical Therapy. I acknowledge that all unpaid balances are subject to a collections process, including all applicable additional fees. **If I have provided an email address, my signature below indicates my approval for email contact if warranted.

_________________________	_______________________________	_____/_____/_____
PRINT NAME	SIGNATURE	DATE

Registering Staff Member Initials Here _____________