Patient Registration and Assignment of Benefits

Patient
Name: First_____ Middle_____ Last_____

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

Statement Mailing Address_____City_____ST_____ZIP_____

Patient SS# _____-_____-_____ Guardian SS#_____-_____-_____

Hm.Ph.# _____ Mobile_____ *Email_____

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_____

Please tell us a little bit about why you chose PRO for your PT services:

☐ **MD Referral** ☐ **Family/Friend Referral** ☐ **Website** ☐ **Social Media** ☐ **Previous Experience**

☐ **Other:** _____

►CONTINUE TO PAGE 2
****We may use your email to send information about services, office closures, etc…***

WORK Comp Carrier and Claims Address _____

Claim Number _____ **Date of Injury** _____

(We have noted and verified the coverage that you provided on initial call, please look it over and bring any changes to our attention for corrections. Please do not withhold any coverage that you have. There is no guarantee that the quoted coverage guarantees payment. This is all subject to change at the time the claim is processed for various reasons.) All services billed to insurance payers are subject to medical necessity and will vary from visit to visit.

PRIMARY INS you provided to be filed _____**Card Scanned** _____

SECONDARY INS you provided to be filed _____**Card Scanned** _____

TERTIARY INS (if applicable to be filed _____**Card Scanned** _____

COPAY per visit_____ Coinsurance per visit _____ we estimate _____per visit excluding any deductible that may apply, this amount will be determined by your insurance company once the claim is processed. You may receive a statement for additional monies due.

Plan Deductible _____Amount Met when benefits checked_____ (this may not be exact as you may have claims in process from other medical providers. Processing of your claim may determine further patient responsibility.

NOTE_____

ANTHEM has a unique benefit for Physical Therapy. Anthem will apply a **copay/coinsurance** of _____**per claim**, however Anthem assigns a separate **copay** of _____ for services that include Manual Therapy. This is determined at time of treatment. Therefore, you may have an additional balance due on the claim beyond the copay initially collected.

MEDICARE PATIENT -The Therapy Cap/Threshold for 2022 is $2,150.00

If required, prior authorization will be obtained. PRO contacts your insurance company as a courtesy to you. The disclaimer by that payer is that there is no guarantee of payment. Every patient is encouraged to understand their individual coverage by directly communicating policy questions to their insurance company.

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

NOTE- If there is any other practitioner or individual that you would like the progress of your treatment shared with outside of the referring provider, please provide that information below and initial your approval.

Name of OTHER medical provider(s) or individual(s) _____

Your Initials Here _____**, Date**_____

Internal Use Only

****Please validate info on form and Rx matches what is in EMR System* Name __ Address__ Phone#__ Referring MD__***

VERIFIED BY_____