Norfolk Physical Therapy Center
Patient Registration Form

Patient Information

Name____SS#______________________
Address____
(**if you receive mail at a PO Box please also provide your complete physical address**)
City____State___________Zip____________
Date of Birth____Age_____________
Home Telephone (   )_____________________Work Telephone (   )_________________
Cell phone (   ) ______________________________
Email address____
Patient sex ( ) Male ( )Female Marital Status________________________
Date of injury/onset_________________Job Related?_________Auto Related?____________
Referring Physician______________________ Next Appointment with Him/Her___________
Address where you normally see Physician____
Rehabilitation Nurse (if any)____
Attorney (if any) _________________________________ phone (   ) _______________

Employment Information

Employer Name____
Address____
City____State___________Zip____________
Telephone (   ) ____________________________Occupation_________________________

Primary Health Insurance____ (copy of card)
Secondary Health Insurance____ (copy of card)

Next of Kin

Name_____________________________
Address___________________________
City, State & Zip___________________
Telephone Number__________________
Relationship_______________________

Emergency Notification (Not living with you)

Name_____________________________
Address___________________________
City, State & Zip___________________
Telephone Number__________________
Relationship_______________________

Consent to Treat/Authorization & Assignment of Benefits

I consent to treatment for physical and/or aquatic therapy as ordered by my physician. I authorize and request payment of medical benefits directly to Norfolk Physical Therapy Center. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original. I understand that I am responsible for any unpaid balance or any services which are not covered by my insurance. In the event that my account is referred to an attorney or collection agency for collection, I agree to pay all reasonable costs of collection, including an attorney's fee and/or collection agency fees.

____Date_____________________
Signed (Patient or Representative)

How did you hear about our services?

☐ **Phone Book** ☐ **Employer** ☐ **Friend** ☐ **Doctor** ☐ **Insurance Company**

____**Date**____________________
NPTC Representative

ACKNOWLEDGEMENT OF NOTICE

I have received and read the Notice of Privacy Practices provided by Norfolk Physical Therapy Center. I understand how my private information may be used and disclosed and I also understand my rights regarding my private health information.

I acknowledge receipt of Norfolk Physical Therapy Centers Notice of Privacy Practices.

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Patient Signature Date

____

Patient Name

____

NPTC Witness Date

HOW MAY WE CONTACT YOU REGARDING APPOINTMENTS?

I ______ do ______ do not authorize NPTC to leave messages regarding appointments at the following locations:

_____ yes _____ no home (answering machine)

_____ yes _____ no work _____________________________ (please provide number)

_____ yes _____ no cell phone _________________________ (please provide number)

_____ yes _____ no email ____

_____ yes _____ no family members (please list) ______________________________

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Norfolk Physical Therapy Center
Insurance Information Sheet

AS A COURTESY, NORFOLK PHYSICAL THEARPY CENTER WILL FILE ALL PRIMARY AND SECONDARY CLAIMS FOR YOU. ANY DEDUCTIBLE, CO-INSURANCE OR CO-PAYMENT IS DUE UPON ARRIVAL AT EACH VISIT. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVIENCE. Payment arrangements for special circumstances may be discussed with our Finance Officer.

MEDICARE
Due to guidelines established by Medicare, it is necessary for you to PHYSICALLY SEE your referring physician every 60 days during your physical therapy treatment. A 30-day interim report prepared by your therapist and signed by your doctor is also required.

TRIGON KEY ADVANTAGE & MAMSI / MAPSI
A pre-authorization number obtained from your primary care physician is required before your first visit. Our office will obtain authorization for additional visits.

M.D.I.P.A. / OPTIMUM CHOICE
Your primary care physician must refer you by submitting a completed referral form to our office by or before your first appointment. Our office will obtain authorization for additional visits from your insurer when necessary.

TRIGON HEALTHKEEPERS OFFERED BY PRIORITY HEALTHCARE, INC.
Pre-authorization by your referring physician is required prior to your first visit. Our office will obtain authorization for additional visits from your insurer as necessary.

TRICARE STANDARD
If you are referred by a military facility, a completed “DD2161 Consultation Sheet” is required. Also, please provide us with the physician’s full name and the address of the facility where you were seen. Physical Therapy visits are usually limited to 2 per week and a total of 20 per year. Keep in mind, for deductible purposes, the Tricare year begins on October 1.

SENTARA PPO / OPTIMA PPO
Pre-authorization must be obtained from the insurer after your physical therapy evaluation. We will submit the required documentation along with authorization request after your first appointment. Once Sentara authorizes further treatment, then we will schedule further visits. We will obtain authorization for any additional visits as needed.

WORKER’S COMPENSATION
If your work injury claim is denied, you will be responsible for the entire balance. If this happens, and we are participating providers with your personal health insurance, we will file the claim to your personal insurer once you provide us a copy of your insurance card.

PLEASE NOTE:
For all patients with commercial insurance, any supplies issued to you are not covered by your insurance. Payment for supplies will be your responsibility at the time the supply is issued.

The information we provide to you about your health insurance benefits is only an estimate based on information we have obtained by calling your insurance carrier. We cannot guarantee payment of any claim. If your insurance company does not pay as anticipated, you may be billed. If you are aware of changes in your health insurance benefits, please advise us as soon as possible so that we can change our records accordingly and maximize your insurance company’s payment on your behalf.

Name:____

Deductible Remaining:________________________________

Co-pay / co-insurance:________________________________

Physical Therapy Maximum:____________________________

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Signed **Dated**

NORFOLK PHYSICAL THERAPY CENTER

Dear Patient:

Welcome to Norfolk Physical Therapy Center! Thank you for choosing our practice for your physical/aquatic therapy needs. We would like to review our policy for filing your insurance for services rendered by our clinical staff. Norfolk Physical Therapy Center participates with Medicare, Blue Cross, Workers Comp and several commercial insurances. Prior to your first visit, we contact your insurance company to verify your benefits. We will advise you of an estimate of the amount due by you at time of service.

While your insurance coverage is a contract between you and the insurance carrier, we will be happy to file a claim for your visit(s). Our practice will require you to assign all insurance company payments directly to our office to avoid any misunderstanding regarding payment for professional services. If you request your insurance company to pay you directly, we will require full payment when services are rendered. You will be responsible for any portion of your bill that is denied or not paid by your insurance carrier.

According to state law, your insurance carrier must remit payment or deny your insurance claim within 60 days. Should a problem arise with receiving payment from your insurance company, you will be notified by our billing office staff.

All patients will be required to establish a written financial arrangement for payment when services are rendered. All co-pays, deductibles and co-insurances are due at the time of service.

Our practice firmly believes that a good Physical Therapist/Patient relationship is based upon understanding and clear communication. Our staff will make every effort available to clarify any questions you have concerning your balance. If you have any questions concerning our policy for filing your insurance or need assistance, please contact our billing department.

Sincerely,
Steve Schall, P.T.

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Patient signature **Date**

Revised 08-07-02

NORFOLK PHYSICAL THERAPY CENTER
839 POPLAR HALL DRIVE * NORFOLK, VA 23502
*(757) 459-2112 * FAX (757) 459-2421

Missed Appointment Policy

At the Norfolk Physical Therapy Center, we strive to provide you with the highest level of professional care . Our commitment to your well being is something everyone in our clinic takes quite seriously. Therefore, it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive. Your adherence to your doctors recommendations is a vital part of your therapy and we have certain rules that need to be followed in order to ensure the best results.

We expect you to keep your appointments. We will provide you with a printout so that you do not forget.

With the exception of serious emergencies, it is expected that you will keep all your appointments. If you need to reshedule an appointment, we require at least 24 hours advance notice. Please call our office and arrange for a make up appointment with our front desk as soon as you know you will be unable to attend your appointment. The make up appointment should be in the same week, preferably the very next day.

If you fail to give 24 hour advance notice of a cancellation to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and inform your physician,employer, or insurer of the fact that your treatment has been discontinued due to non compliancewith the prescribed rehabilitation order.

We appreciate you greatly as our patient and together we can achieve wonderful results and successes from you.

Steve Schall MS,PT,OCS
Norfolk Physical Therapy Center

I have read and understand this policy.

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Signature Date