900 2nd St. South, Suite 2 Great Falls, MT 59405
Phone (406)770-3171 Fax (406)770-3173

PATIENT REGISTRATION

(Please print clearly)

Full Name_____DOB_____
Address_____
City/State/Zip _____
Home Phone _____Cell Phone_____
Social Security #_____ Male/Female_____
Email_____
Employer_____Employer Phone #_____

Spouse's Name_____DOB_____
Social Security #_____
Employer_____Employer Phone #_____

PRIMARY INSURANCE INFORMATION

Insurance Company_____
Policy Holder_____ Date of Birth_____
Subscriber #_____Group #_____
Attorney/Case Worker Phone # _____

SECONDARY INSURANCE INFORMATION

Insurance Company _____
Policy Holder_____ Date of Birth _____
Subscriber #_____Group #_____

Referring Provider:_____Reason for visit:_____

Is this injury accident related? Yes/No **Car Accident?** Yes/No **Work Related?** Yes/No

INFORMED CONSENT FOR TREATMENT

I understand that I am now under the care and supervision of the providers of Advanced Practice Physical Therapy, Inc. I understand that it is the responsibility of Advanced Practice Physical Therapy, Inc and its staff to carry out the instructions of the providers. I consent to physical therapy services rendered to me and the expressed or implied instruction of my provider. I understand that any services furnished to me outside of the scope of any instruction, express or implied, of my provider or designee are not performed on behalf of , or at the direction of Advanced Practice Physical Therapy, Inc.

Assignment and Release

I certify that I, and/or my dependent(s) have insurance coverage with above listed insurance company and assign directly to Advanced Practice Physical Therapy, Inc all insurance benefits. If any otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or in one year from the signed date below.

_____ _____

Signature **Date**

Advanced Practice Physical Therapy

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PAYMENT POLICY

1. **Billing Insurance:** It will be our pleasure to bill your insurance company for you, provided that you submit accurate billing information.
2. **Co-Pays:** Co-Pays are expected at the time of services, no exceptions. It is your contractual agreement with your insurance to pay your co-pay at the time of service.
3. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you with the payment expected within 30 days.
4. **Nonpayment:** If your account is over 60 days past due, we will expect payment in full before further treatment is provided by our facility. Understand that you will be charged a late fee of $10.00 a month for accounts that are past due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You will be responsible for any collection fee incurred and you and your immediate family members may be discharged from this practice.
5. **Missed Appointments:** Please notify us of a canceled appointment by 5:00 PM of the prior day. Our policy is to charge up to $100.00 fee for missed appointments. These charges will be your responsibilities and billed directly to you.
6. **Payments:** If you are currently without insurance coverage, we offer a discount for payment in full at the time of service. We accept payments by cash, check, or credit card.
7. **Medicare:** Medicare has a new ruling for private practice physical therapy offices: you must be seen by your doctor prior to starting therapy and the prescription is good for 30 days from the first day you start your therapy. After the 30 days have expired Medicare requires that we send your physician an updated treatment plan to continue your physical therapy. Medicare does not cover 100% of physical therapy and I understand that I am responsible for the remainder of the balance.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR ALL CHARGES, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY COVERAGE.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

SIGNATURE:_____ **DATE:**_____

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RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have received a copy of the Advanced Practice Physical Therapy, Inc. Notice of Privacy practices.

Signature:_____Date:_____

EMERGENCY CONTACT

Name: _____
Phone_____Cell Phone_____Employer's Phone_____

Name: _____
Phone_____Cell Phone_____Employer's Phone_____

Name: _____
Phone_____Cell Phone_____Employer's Phone_____

REFERRAL

Who can we thank for referring you? _____

Thank you for choosing Advanced Practice Physical Therapy, Inc. We appreciate your business and hope to exceed your expectations. If you appreciate our services please refer us to your family, friends, coworkers, and physician. Thank you for your business.