MOUNTAINSIDE PHYSICAL THERAPY, INC.
12625A LEE HIGHWAY
WASHINGTON, VA 22747-1931
Ph.: 540-987-9390 Fax: 540-987-9392

NEW PATIENT REGISTRATION FORM

GENERAL PATIENT INFORMATION

PATIENT'S FULL LEGAL NAME:____MARITAL STATUS:_____________

DATE OF BIRTH: ___/_____/____ AGE:________ GENDER:__________ SOCIAL SECURITY #:______________________

STREET ADDRESS: ____CITY/STATE:______________________ZIP_________

HOME PHONE: _______________________CELL PHONE: ___________________WORK PHONE:_______________

EMAIL ADDRESS: _________________________________ WHERE MAY WE LEAVE PHONE MESSAGES:________________

OCCUPATION: _____________________EMPLOYER:___________________________CONTACT #:____________________

REFERRING PHYSICIAN:__________________________________PHONE:____

INSURANCE INFORMATION: (Please give your insurance card(s) to the receptionist)

PRIMARY INSURANCE:_____________________________MEMBER ID #:_____________GROUP #:___________________

SECONDARY INSURANCE:__________________________MEMBER ID #:_____________GROUP #:___________________

PERSON RESPONSIBLE FOR BILL: _____________________________RELATIONSHIP:_________________D.O.B:________

ARE YOU SEEKING TREATMENT FOR A WORK RELATED OR PERSONAL INJURY___________________________________

By signing this form, I am giving Mountainside Physical Therapy, Inc. permission to use and disclose my protected health information for the purpose of treatment, payment and health operations only.

CANCELLATION POLICY: We realize it is not always possible to keep scheduled appointments and emergencies do occur. However, whenever possible please give us at least 24 hours' notice if you are unable to keep a scheduled appointment, so that we may be able to fill the cancellation time slot. A $60.00 fee will be charged to your account if notice is not given. Your commitment and effort in honoring this policy along with your understanding is greatly appreciated. Please ask a member of our staff if you have further questions regarding the cancellation policy.
Patient Signature:__________________________Date:_____________

MOUNTAINSIDE PHYSICAL THERAPY, INC. POLICIES:
IN CASE OF EMERGENCY: NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING IN YOUR HOME):
NAME: ___________________________RELATIONSHIP:____________HOME #:_______________CELL#:_____________
HOME HEALTH STATUS: HAVE YOU BEEN RECEIVING HOME HEALTH TREATMENTS OF ANY KIND: ____YES ____NO
IF YES PLEASE PROVIDE RECEPTIONIST WITH A COPY OF YOUR HOME HEALTH DISCHARGE SUMMARY OR CONTACT INFORMATION FOR YOUR HOME HEALTH PROVIDER. PLEASE NOTE: INSURANCE WILL NOT COVER HOME HEALTH SERVICES AND OUTPATIENT REHABILITATION SERVICES CONCURRENTLY.

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.
BASIC POLICY: Payment is due in full at the time services are rendered.

PATIENT/GUARDIAN
SIGNATURE:____DATE:____________________________
If this form is signed by someone other than the patient, please list reason for inability to sign:______________________

MOUNTAINSIDE PHYSICAL THERAPY, INC.
12625A LEE HIGHWAY
WASHINGTON, VA 22747-1931
Ph.: 540-987-9390 Fax: 540-987-9392

PATIENT WITH INSURANCE: All co-payments and deductibles are due at the time of service. We may bill your insurance carriers for you, if we have a current contract with the carrier. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid within 60 days of billing; our fees are due and payable in full, from you.

NON-COVERED SERVICES: If any care is not paid for by your existing insurance coverage, payment in full is expected at the time of service or immediately upon notice of insurance claim denial.

PERSONAL INJURY CASES: We will bill, per your instructions, the insurance company or attorney involved with expectations of a reasonable turnaround time for payment. In cases of long term settlement cases, requiring extended time for payment, an 18% interest per annum on unpaid balances will be assessed.

RECORD COPYING POLICY: A legal request for records must be filled out and signed. From date we receive the signed form in our office, it may take up to 15 days to process and mail out your record. There will be a fee attached to copying any patient records. FEES: An initial file retrieval fee of $10 for charts up to 50 pages and $20 for charts over 50 pages. Additionally, there will be a $ .50 per page fee for the first 50 pages copied and $ .25 per page for all pages past the 50th. These fees cover the cost of paper, toner, and time for a staff member to copy the record.

COLLECTION AGENCY COSTS: In the event your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees, or court costs.

ASSIGNMENT OF INSURANCE BENEFITS: I ____________________________herby assign all medical benefits for which I am entitled, private insurance, and other health plans, to Mountainside Physical Therapy, Inc. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorize said assignee to release all information necessary to adjudicate all claims and secure payments for services rendered.

MEDICARE PATIENTS: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits to be made to Mountainside Physical Therapy, Inc. for any services furnished to me by listed provider. I authorize my holder of medical information to release to the Centers for Medicare and Medicaid Services and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of information necessary to adjudicate the claim. If "other insurance" is indicated on the CMS-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the patient is responsible for the deductible, coinsurance, and any non-covered services.
MEDICARE #:_____________________________SIGNATURE:_____________________________DATE:______________

PATIENT/GUARDIAN
SIGNATURE:____DATE:____________________________
If this form is signed by someone other than the patient, please list reason for inability to sign:______________________