Norton Physical Therapy

Confidential Registration Form

Name: _____ DOB: _____

Address: _____ City: _____ Zip: _____

SS#: _____ Male/Female Status: Married/Divorced/Single/Other

Cell #_____ Home # _____ Work # _____

Employer: _____ Occupation: _____

Emergency Contact _____ Phone #_____

Referring MD: _____ Phone #: _____

PCP: _____ Phone #: _____

Primary Health Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Employer: _____ Phone #: _____

Secondary Health Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Employer: _____ Phone #: _____

Is this injury work related? _____ if YES: Insurance Co.: _____

Phone #: _____Date of Injury: _____ Claim # _____

Is this auto related? _____ if YES: Insurance Co.: _____

Phone #: _____Date of Injury: _____ Claim # _____

Attorneys name: _____ Phone #: _____

Norton Physical Therapy

Confidential Registration Form
Part Two

Have you had Physical Therapy in the past 365 days? YES NO

You are responsible for keeping your scheduled appointments.

Do you want reminder calls? YES NO

May we leave a message regarding your appointments on your voicemail?

YES NO

People/Person we may change/discuss a scheduled appointment with on your behalf.

Name: Relationship:

Name: Relationship:

Name: Relationship:

I hereby agree and give consent to medical treatment in treating my physical condition. I authorize the release of my medical information needed to process my claim. I understand I am responsible for any changes that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to _____ regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

Norton Physical Therapy

184 West Main Street, Suite 102. Norton, MA. 02766
Telephone: (508) 622-0235 Fax: (508) 622-0399

CLIENT ACKNOWLEDGEMENT FORM

Cancellation Policy: if you must cancel an appointment a twenty-four hour notice is required or a $25.00 fee is charged. There is no charge if you can reschedule the appointment you are cancelling.

No Show Policy: If a patient does not show for an evaluation or a scheduled appointment there will be a $50.00 charge. If a patient misses two scheduled appointments without calling, it will result in a discharge from physical therapy as non-compliant for non-attendance. The referring physician and/or insurance company will be notified.

Co-Payments/Co-Insurance/Deductible Payments Policy: Patient co-payments are due at the time of treatment. Patients will receive an invoice/bill for co-insurance and deductible payments as their insurance company notifies us of the patient responsibility portion. All co-insurance and deductible payments are due within 30 days of invoice.

- Please call your insurance company for information related to your copayments, co-insurance and/or deductible payments.
- We accept cash, checks, and credit card payments.

I acknowledge my understanding and willingness to comply with the office policies:

- Cancellation / No-Show Policy
- Co-payment / Co-insurance / Deductible Payment Policy

I understand that I am responsible to inform the office staff and clinician immediately about insurance and billing changes.

I understand that if my account is not paid within 30 days it will considered delinquent. Delinquent accounts are sent to collections and a 25% collections fee will be added to the balance due. To remove a delinquent account, the full balance and 25% collections fee must be paid in full.

Patient Name: _____ Date: _____

Patient's Signature: _____

Signature of Responsible Party (if not the patient) _____

Benefit Acknowledgement

Health Insurance Company _____

Copay $: _____Deductible $: _____ Met $:_____ Co-Insurance :_____

Max # of Visits per Cal Yr/Plan Yr _____ Patients Initials: _____

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Date : _____

I, _____ (name)

_____ DO give permission to Physical Therapy of Norton

_____ DO NOT give permission to Physical Therapy of Norton

to release pictures of me to their Instagram page and Facebook page.

Sign : _____

Print : _____