Linde Physical Therapy Registration Form

Patient Information

Name _____ _____ _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State ____ Zip _____ Home Phone _____

E-mail _____ Cell Phone _____

Sex M☐ F☐ Age _____ Birthdate _____ Marital Status M☐ S☐

Employer/School attended _____ Occupation/Grade _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Name of referring Physician _____ Phone _____

May I contact the above to review your case? Yes ☐ No ☐

In case of emergency who should be notified? _____ Phone _____

Primary Care Physician _____ Phone _____

May I contact the above to review your case? Yes ☐ No ☐

Primary Insurance

Person responsible for account _____ _____ ____
Last Name *First Name* *Initial*

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address(If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Insurance Company _____

Member ID # _____ Group # _____

Secondary Insurance

Person responsible for account _____ _____ ___
Last Name *First Name* *Initial*

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address(If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Insurance Company _____

Member ID # _____ Contract # _____ Group # _____

Medicare Only

Have you received physical therapy this year? Yes ☐ No ☐

If YES, how many visits did you have? _____

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with _____
Name of insurance company

and assign directly to ***Linde Physical Therapy Inc.*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ***Linde Physical Therapy Inc.*** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest at 1.5%per month (18%per anum), and all court costs.

_____ _____ _____
Responsible party signature *Relationship* *Date*

Linde Physical Therapy

3913 Old Lee Highway, Suite 31C
Fairfax, VA, 22030
Phone: (703) 877-2224
Fax: (703) 277-1962

OFFICE POLICIES

The following is a list of office policies. Please read them carefully and sign below. If you have any questions or concerns, please ask for clarification. A copy is available at your request.

Insurance:

I am only accepting a limited number of health care insurance policies. I may terminate with a company at my discretion but will give you notice of this ahead of time.

Important note: Your insurance company may decide that certain treatments are not necessary and may choose to deny payment for these services. Any treatment provided is in your best interest and is an integral part of your recovery. We will appeal this decision; however, if it is not ruled in our favor, you will be responsible for the outstanding amount.

Missed Appointments:

When you book an appointment that time is reserved for you. If you are unable to attend you are required to give 24 hours notice so that the time can be used to schedule another appointment with someone else. Failure to give this notice will result in you being billed the self-pay rate for the missed appointment. The rate for the missed appointment will be $60.00. Even if you have insurance that I accept it is your responsibility to pay for the missed appointment as your insurance will not.

Billing:

Payment is expected at the time service is rendered. In some cases a monthly statement will be sent out if discussed with me ahead of time. Failure to pay within 30 days of the statement being issued will result in no further appointments being made until such time as your account is paid in full. This policy is applied to all appointments both those attended and missed without giving notice.

If I am accepting your insurance it is expected that they will pay within 90 days of being issued the claim. Failure on their part to pay me will result in you receiving a bill for the outstanding balance. You will then have 30 days to correct this with the insurance company or pay me the outstanding balance.

Confidentiality:

All information that you provide is kept confidential. The normal ***Policy*** is to provide the referring physician and your insurance company, if they are responsible for payment of services rendered, with medical information relating to the current treatment. Your signature on the registration form allows me to provide information to the referring physician and the insurance company. Release of information to any other party would require you to sign a release of information document.

I have read the above policies and agree to comply with them.

Signature _____ Date _____

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Web Page: www.lindept.com

Verification of Benefits for Physical Therapy

*Please verify your benefits for **Linde Physical Therapy** with your insurance company and return this form at your next visit.*

Due to insurance company information inconsistencies, it is important that you confirm whether your plan is IN or OUT of network with Linde Physical Therapy.

Last Name: _____ First Name: _____

Insurance Company: _____

Number of visits allowed per calender year: _____

Deductible Amount: _____

Co-pay amount: _____

Pre-authorization required? Yes ☐ No ☐

If yes, provide details:

Additional information:

Signature _____ Date _____