-PIONEER-
PHYSICAL THERAPY

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PIONEER PHYSICAL THERAPY
PATIENT REGISTRATION RECORD

PATIENT:
Name: ____

Address:_______________________________________ City, State, Zip:___________________________________

Home Phone: (   ) ____________________________ Cell Phone: (   )________________________________

Date of Birth: ____________________________________ Sex: Male Female

Marital Status: ___________________________________ E-mail Address: ________________________________

EMPLOYER:
Employer Name:___________________________________ Employer Phone #: _____________________________

Employers Address:_______________________________ City, State, Zip: _________________________________

PHYSICIAN:
Primary Physician: ________________________________ Physician Phone: (   )__________________________

SPOUSE:
Spouse/Next of Kin:________________________________ Phone: (   )__________________________________

Emergency Contact: ______________________________ Phone: (   )__________________________________

****I understand that it is my responsibility to verify my insurance benefits****

INSURANCE: _________________________________ Policy #:_______________________________________

SECONDARY INSURANCE:_______________________ Policy #:_______________________________________

GUARENTOR'S INFORMATION: Person responsible for bill if other than patient
Name: ____ **Guarantor's Date of Birth** __________________________

Relationship:______________________________________ Address: _____________________________________

City, State, Zip ____________________________________ Phone Number: (   ) __________________________

GENERAL CONSENT

I, the undersigned patient or patient's representative, request admission to Pioneer Physical Therapy, PLLC for care and treatment. I certify that the information given is correct. I am aware that the practice of physical therapy is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment or examination. I consent to and authorize the following:

FINANCIAL AGREEMENT: I certify that the information given in applying for payment under government or private insurance is correct. I understand that any insurance benefit information given to me by any employee of Pioneer Physical Therapy, PLLC is based on general information they have received from the insurance carrier and may not specifically address my benefit package. I understand that it is my responsibility to know my specific benefits. I understand that I am financially responsible to Pioneer Physical Therapy, PLLC for charges not covered by my insurance carrier. Pioneer Physical Therapy, PLLC reserves the right to impose reasonable financing and late charges. Finance charges may be charged to balances over 60 days at the rate of 9% per annum. If my account becomes past due, I/we agree to pay all attorney fees, court costs, filing fees and process service fees which may be assessed by any collection agency or law firm retained to pursue the matter and for the venue and jurisdiction to be in Skagit County.

Pioneer Physical Therapy, PLLC and/or their assignees are hereby authorized to contact me at any telephone numbers, including pagers, and cell phone numbers, provided by me or otherwise obtained by Pioneer Physical Therapy, PLLC, using an automatic telephone dialing system and to leave prerecorded messages on these devises.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to Pioneer Physical Therapy, PLLC, including major medical insurance coverage.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

PERSONAL VALUABLES: I acknowledge that Pioneer Physical Therapy, PLLC shall not be liable for the loss or damage of any money, jewelry, documents or other articles of value.

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CANCELATION/ NO SHOW POLICY
Pioneer Physical Therapy requires 24-hour notice for the cancellation of a scheduled appointment. There is a $25 charge for a no-show or cancellation without proper notice. This charge *will not* be covered by your insurance. We understand that extenuating circumstances may occur which is why we have implemented a "two-strike" policy. We will allow for two cancellations before charging a fee. For every cancellation or no- show beyond two, a $25 fee will be assessed. Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no shows will hinder your care and may result in discharge from our facility.

TARDY POLICY
It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available, however; simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 10 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive more than 10 minutes early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:
1. You, the patient – for not receiving the treatment you need
2. Your therapist – as now he or she has a gap in the schedule
3. Another patient – who could have had your appointment time

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or *not* having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

I consent to the above, as indicated by my signature below:

Patient or other legally responsible persons signature:____

Printed Name:_______________________________ **Date**:_______________________________

Relationship of legally responsible person to patient: ____

Subsequent Visits:

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________

Signature:_______________________________ **Date**:_______________________________