

THE THERAPY

services associates

P.O. Box 811
 Lovington, NM 88260
 575-396-8540
 FAX 575-396-2187
 therapylovington@leaco.net

PROFESSIONAL CORPORATION
 www.therapyservicespc.com

2700 N. Grimes
 Hobbs, NM 88240
 575-392-4129
 FAX 575-392-3835
 therapyhobbs@leaco.net

PATIENT REGISTRATION BLACK INK ONLY PLEASE PROVIDE PHOTO ID & INSURANCE CARD(S)

Date: _____	New Patient _____ Established Patient _____
Patient Name: _____	Referring Dr: _____
Address: _____	_____
_____	NPI #: _____
Phone: _____	Phone #: _____
Cell: _____	_____
Email: _____	Fax #: _____
Birth Date: ____/____/____ Sex: _____	Primary Care Dr: _____
Soc. Sec. Number: _____	Employment Related: Yes No
Insured Name: _____	Auto Related: Yes No State: _____
Address: _____	Slip & Fall (Other Accident): Yes No
Insured SSN: _____	_____
Insured Employer: _____	Are You Receiving Home Health? Yes No
Insured Date of Birth: _____	_____
Patient Relation to Insured: _____	Involved Body Part: _____
Patient's Employer: _____	_____
Address: _____	Emergency Contact: _____
Occupation: _____	Relation to Patient: _____
Work Phone: _____	Emergency Phone #: _____
Primary Ins: _____	Secondary Ins: _____
ID#: _____	ID#: _____
Group #: _____	Group#: _____
Phone #: _____	Insured's Name: _____
Claim#: _____	Insured's DOB: _____
Date of Injury: _____	Insured's SSN: _____
Medicare #: _____	Phone #: _____
Medicaid #: _____	Insured's Employer: _____

For Office Use Only:

Treatment Start Date: ____/____/____ Time: _____ Therapist: KO DT MS AP MV

NAME _____

PLEASE READ AND SIGN

I, _____, agree to pay \$_____ each treatment OR

I, _____, agree to pay \$_____ weekly in advance .

Return Check Fee: If any check or other instrument for payment on your account is dishonored for any reason, you agree to pay a Returned Check Fee of \$25.00. If suit is filed, we reserve the right to sue for triple the amount of the check up to \$500.00 with a minimum of \$100.00.

Change of Name, Address, or Employment: You agree to give us prompt notice of any change in your name, mailing address, or place of employment.

AUTHORIZATION TO TREAT AND RELEASE INFORMATION: I hereby authorize Therapy Services Associates (TSA) to treat the patient indicated on the other side of this page. The undersigned authorizes Therapy Services Associates, P.C. to release medical or other information about the patient, which may be necessary for the completion of insurance claims, review of services, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payers, including the third-party payer's agent and/or representative.

ASSIGNMENT OF BENEFITS: The undersigned authorizes payment of benefits, including insurance benefits, otherwise payable with respect to the patient, to Therapy Services Associates, P.C.. The undersigned agrees to assist in the processing of claims for benefits.

MEDICARE AUTHORIZATION: I certify 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 and Healthcare Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request the payment of authorized benefits be made on my behalf to Therapy Services Associates, P.C. during my treatment.

FINANCIAL RESPONSIBILITY: The undersigned jointly and severally agree to pay for all treatments administered by Therapy Services Associates, P.C. It is understood and agreed charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable attorney fees, late charge fees, and returned check fees are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned, jointly and severally, agree to pay all charges not paid in full by a third-party payer. If I have insurance, I understand that my insurance company has entered into a contract with me and not with Therapy Services Associates, P.C. and I am responsible for payment for all services rendered to me.

Your signature means that you have read and agree to the terms of this Pay Agreement and authorize Therapy Services Associates, P.C. to perform a credit check if deemed necessary.

_____/_____/_____
SIGNATURE DATE WITNESS

RELATION TO PATIENT

PATIENT INFORMATION

PATIENT NAME _____ **DATE** _____

Type of problem: _____ Date of Onset: _____

How were you hurt? _____

Do you have a lawyer helping you regarding this injury? ___ Yes ___ No

Attorney Name: _____

Address: _____ Phone: _____

Have you had surgery? Yes No Type of Surgery: _____

Date of Surgery: _____

Do you have loss of feeling? _____ If yes, where? _____

Is loss of feeling constant or intermittent? _____

List medications: _____

What are your goals for therapy? Please check all that apply:

___ Decrease Pain ___ Decrease Muscle Spasm ___ Decrease Swelling ___ Improve Strength

___ Improve Flexibility ___ Improve Ability to Walk ___ Improve Ability to _____

___ Other _____

Work status:

0=Do not work outside the home

1=Unable to work

2=Working limited hours **and** with restrictions

3=Working limited hours **or** with restrictions

4=Working with no restrictions

I hereby authorize Therapy Services Associates, P.C. (TSA) to treat the patient indicated on this page.

SIGNATURE (Must be 18)

_____/_____/_____

(WITNESS)

NAME: _____

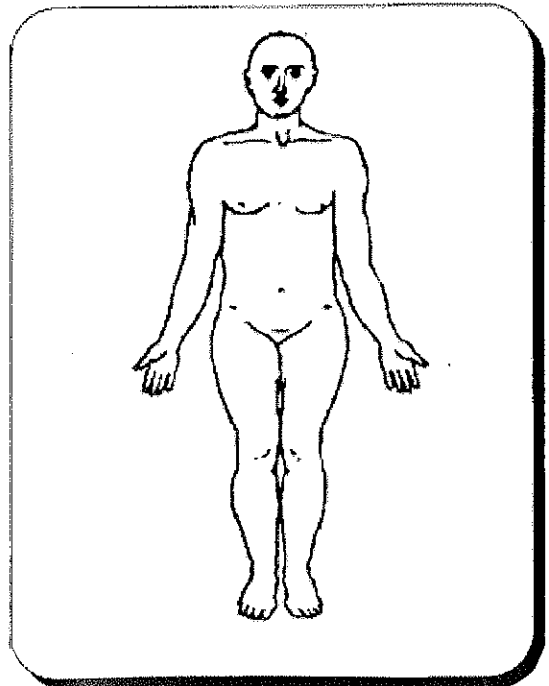
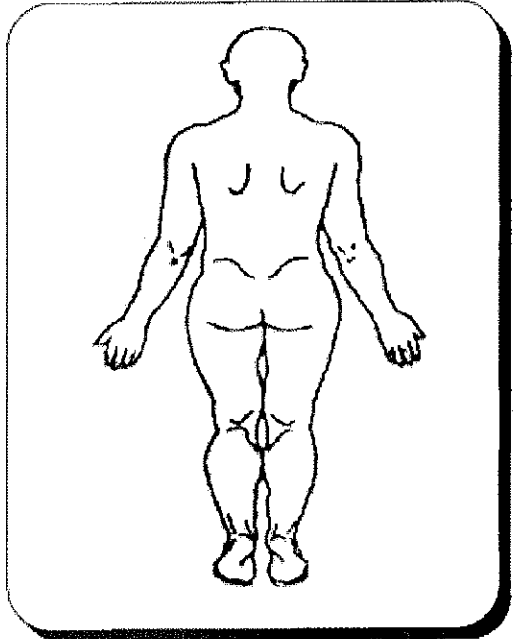
DATE: _____

Please check any of the words that describes your pain under the column that describes it's intensity.

PLEASE DRAW YOUR PAIN

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				

xxx	Burning	==	Numbness
!!	Stabbing	**	Cramping
00	Aching	##	Other



Your Pain is:

On Most Days No Pain Mild
 Discomforting Distressing
 Horrible Excruciating

At It's Worst No Pain Mild
 Discomforting Distressing
 Horrible Excruciating

At It's Best No Pain Mild
 Discomforting Distressing
 Horrible Excruciating

TODAY No Pain Mild
 Discomforting Distressing
 Horrible Excruciating

How many hours of the day are you in pain? _____

How many day per week are you in pain? _____

How many weeks per year are you in pain? _____

What Drugs Have You Taken Today? _____

.....

Your Pain Today - Mark along scale below.

No Pain - [_____] Worst Possible Pain

Privacy Policy Consent
CONSENT FOR PURPOSES OF TREATMENT, PAYMENT
& HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by **Therapy Services Associates, P.C.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Therapy Services Associates, P.C.** I understand that diagnosis or treatment of me by **Therapy Services Associates, P.C.** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Therapy Services Associates, P.C.** is not required to agree to the restrictions that I may request. However, if **Therapy Services Associates, P.C.** agrees to a restriction that I request, the restriction is binding on **Therapy Services Associates, P.C.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Therapy Services Associates, P.C.** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created and received by my therapist, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Therapy Services Associates, P.C.**'s Notice of Privacy Practices prior to signing this document. The **Therapy Services Associates, P.C.**'s Notice of Privacy Practices has been made available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Therapy Services Associates, P.C.** The Notice of Privacy Practices for **Therapy Services Associates, P.C.** is posted in the lobby and on **Therapy Services Associates, P.C.** website at www.therapyservicespc.com. This Notice of Privacy Practices describes my rights and the **Therapy Services Associates, P.C.**'s duties with respect to my protected health information.

Therapy Services Associates, P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing **Therapy Services Associates, P.C.** website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

III.M.3

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Cancellation and No Show Policy

Patient's name: _____ Date _____ :

Thank you for choosing **Therapy Services Associates, PC** to provide your physical therapy.

Please read the following policies, initial each one, then sign your name at the bottom of the page. We take this subject seriously at **Therapy Services Associates, PC** because it can make the difference in the success of your treatment. Your therapist and physician have prescribed a set frequency of treatment. Showing up as scheduled for these visits and following the physical therapist's instructions are an important part of managing your health condition.

Cancellation Policy:

If you need to cancel a Physical Therapy appointment, please call us as soon as possible (4 hours notice) so we have the opportunity to offer your appointment to another patient. If less than 4 hours notice is given you will be charged a \$30 cancellation fee*.

Initial _____

No Show Policy:

If you do not show up for a scheduled appointment, you will be charged a \$30 no show fee*. Two consecutive no show appointments will result in you being taken off the schedule.

Initial _____

Workmen's Compensation Patients:

Documentation of any missed appointments will be forwarded to your Case Manager, Adjustor, and referring physician. By missing appointments you could jeopardize your claim.

Initial _____

I understand the terms of this form. I realize that I am financially responsible for charges incurred from cancellations or no shows.

Patient's signature: _____

Parent's signature (if patient is a minor): _____

* No show/cancel fee not applicable to Medicaid Insurance.