2700 N. Grimes
Hobbs, NM 88240
575-392-4129
FAX 844-292-4019
therapyhobbs@leaco.net

THERAPY
services associates
EST. 1985
www.therapyservicespc.com

P.O. Box 811
Lovington, NM 88260
575-396-8540
FAX 844-292-4019
therapylovington@leaco.net

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

Date:_____ **New Patient** _____ **Established Patient** _____

Patient Name: _____
Address:_____
_____
Phone:_____
Cell:_____
Email: _____
Birth Date: _____/_____/_____ Sex: _____
Soc. Sec. Number: _____
Insured Name: _____
Address: _____
Insured SSN: _____
Insured Employer: _____
Insured Date of Birth: _____
Patient Relation to Insured: _____
Patient's Employer: _____
Address: _____
Occupation: _____
Work Phone: _____
Primary Ins: _____
ID#: _____
Group #: _____
Phone #: _____
Claim#: _____
Date of Injury: _____
Medicare #: _____
Medicaid #:_____

Referring Dr: _____
_____
NPI #: _____
Phone #: _____
Fax #: _____
Primary Care Dr: _____
Employment Related: Yes No
Auto Related: Yes No State: _____
Slip & Fall (Other Accident): Yes No
_____
Are You Receiving Home Health? Yes No
_____
Involved Body Part: _____
_____
Emergency Contact: _____
Relation to Patient: _____
Emergency Phone #: _____
Secondary Ins: _____
ID#: _____
Group#:_____
Insured's Name: _____
Insured's DOB: _____
Insured's SSN: _____
Phone #: _____
Insured's Employer: _____

****

For Office Use Only:
Treatment Start Date: ____/____/____ Time: _____ Therapist: KO DT MS JD MV BA

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

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Therapy Services Associates, PC ("the Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 2700 N. Grimes, Suite C, Hobbs, New Mexico 88240. Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions): _____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

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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.

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)