Patient Registration Form

Name____

Home phone____________________ Cell phone ____________________________

Email____

Would you like a reminder text before your appointment? Yes / No

Date of Birth ____________Age_______Height ____________Weight _________

Home Address ____

City/State/ Zip code ____

Emergency Contact (name, phone) ____

Employer ____

Business phone number ____

Insurance Provider ____

If Medicare is it: primary or secondary **(if primary Medicare, bill cannot be turned into either insurance)**

Do you need a receipt to turn in to your insurance company for out- of-network charges? Yes / No

Physicians (primary/specialist/phone numbers) ________________________________

What is your primary pain ____

Date of Injury ____

How did this injury/ exacerbation occur _______________________________________

____

Initials_____

Pain is worse in (circle all that apply): Morning / During the day / at night / constant / with activity / at rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization) Please rate your pain at its best __________ and at its worst ________

Recent medical testing ____

____

____

Have you received previous treatment for this condition? Yes / No If yes, please summarize

____

____

____

Medications (attached sheet if preferred)

____

____

____

Previous surgeries include dates, if possible

____

____

____

What is your goal for therapy at this time? ____

____

Initials_____

Current and Past Medical Conditions: Circle what applies

Osteoporosis/ osteopenia	Diabetes	Cancer/type:	Stroke or TIA
Heart Conditions	Pacemaker	High Blood Pressure	Respiratory Problems
Asthma	Tuberculosis	Epilepsy/seizures	Bladder dysfunctions
Irritable bowel syndrome	Constipation/ diarrhea	Abdominal surgeries	Heartburn/reflux
Swallowing difficulty	Thyroid dysfunctions	Sleep dysfunctions	Energy loss
Head trauma	Dizziness/fainting	Blood Clot/ Emboli	Car accident
Pregnancy	Pelvic floor problems	Weight loss/gain	Depression
HIV/AIDS	Hearing dysfunctions	Vision dysfunction	Psychological problems
Bleeding Disorders	Osteoarthritis	Rheumatoid Arthritis	Angina (chest pain)
Chronic Obstructive Pulmonary Disease (COPD)	Congestive Heart Failure (CHF)	Degenerative Disc Disease	Emphysema
Heart Attack	Multiple Sclerosis	Parkinson’s Disease	Peripheral Vascular Disease
Headaches	cancer	Hepatitis A, B, C	Hernia
Immunosuppressa nt Condition or Medication	Metal Implants	Ringing in your ears	Smoking
Special Diet Guidelines	Kidney Problems	Upper Gastrointestinal Disease (ulcer, hernia, reflux)	Other: __________

Initials_____

Authorization for Care/Informed Consent

I/we hereby authorize to receive care by BodySync Physical Therapy. The term "informed consent' means that the potential risks, benefits, and alternatives of physical therapy have been explained to you. I/we understand that receiving physical therapy or maintenance care may involve stress of musculoskeletal tissue that may cause soreness (like one might feel for a few days after starting a workout program such as running or lifting weights). Potential risks include, but are not limited to cardiovascular, muscle, ligament, joint or disc injury. Symptomatic aggravation of your current condition is also possible, but usually temporary. I/we understand that the provider may need to perform mobilization techniques, manipulation techniques, massage techniques, manual traction, distraction, electrical stimulation, taping, bracing, orthotic fitting, range of motions, muscle and movement facilitation, weight training and other movement modalities that may produce brief (several days) soreness and discomfort. It is my responsibility to communicate any difficulties that I/we are having during treatment to my physical therapist. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.
Potential benefits may include: increased flexibility, strength, awareness, endurance, mobility, improved cardiovascular endurance and coordination, and better circulation. I may experience decreased pain and discomfort.

Please acknowledge consent with full knowledge of the nature, risks and purpose of the evaluation and treatment program. Initial ______

Medicare's Mandatory Claims Processing Requirement Cash Pay Exception

Under rules promulgated in 2013 by the Department of Health and Human Services under the Health and Insurance Portability and Accountability Act of 1996 (HIPAA) an exception to Medicare's mandatory claims filing requirement has been created. In the 2013 guidance, HHS notes an existing proviso in Medicare law that if a Medicare patient refuses, of his/her own free will, to authorize the submission of a bill to Medicare, then the practice is not required to submit a claim to Medicare for the covered service and may accept an out-of-pocket payment, in full, from the patient.
Under HIPAA healthcare providers, BodySync Physical Therapy must allow a patient's request regarding restrictions on use or disclosure of his/her protected health information (PHI). This is only permissible if the patient, of his/her own initiation, requests to pay, in full (out of pocket) for a service or item. While the law does not require the restriction requests to be in writing it does mandate that the provider document any restrictions to which it has agreed (or is required to agree). It is however, BodySync Physical Therapy policy to obtain the requesting patient's attestation that the request was initiated by him/her.
My signature below is an attestation that I have read the above information presented as a result of my request to be a cash paying patient. I further attest that no one has provoked or encouraged the self-payment option I have elected.
Initial_____

Please sign and print your full name below

Signature ____

Patient's Printed Name ______________________**Date** ___________

Initials_____

Payment Policy

The physical therapy services you receive are provided on a cash pay basis. Payment is expected by cash, check or credit card at the time of visit unless other mutually agreed upon arrangements have been made. Medicare patients may only be seen if they refuse, of their own initiative to allow submission of their bill. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. You may request a detailed statement that can be turned into your insurance company for out of network benefits. **Initial** ________

Clinic Visit (50-55 minutes)

- Initial Evaluation Visit	$250.00
- Follow-up Visit	$195.00

Home Visit (60 minutes)

- Initial Evaluation Visit	$500.00
- Follow-up Visit	$390.00

TeleHealth Visit

- Initial Evaluation Visit	$250.00
- Follow-up Visit	$195.00

No-Show/Cancellation Fee (canceling <24 hours prior to scheduled appointment) $75

Full payment is due at time services are rendered.
Forms of payment:

- HSA cards*
- FSA cards*
- Debit cards (Visa, Discover, MC, NO American Express)*
- Check
- Cash (EXACT AMOUNT ONLY)
- VENMO (@AngieCain86)

*Processing fee of 3.15% applied to all card payments.
Check, cash, and Venmo no processing fee.

Attendance Policy and Cooperation with Treatment

In order for physical therapy to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.
In the event you are unable to keep a scheduled appointment or participate in your program, I will notify my therapist by text, phone call or email at least 1 day prior to my scheduled appointment. If I no show or cancel an appointment in less than 24 hours, I understand I may be charged a $75 fee for the missed appointment.
Initial _______

Initials_____

HIPPA Privacy Policies

The Health Insurance Portability and Accountability Act's Privacy Rule (HIPPA) is a regulation that requires BodySync Physical Therapy LLC to make sure that your medical information is kept private and that you are notified of privacy practices with respect to your medical information.

Notice of Privacy Practices

Effective April 14, 2003

THIS NOTICE DESCRIBES HOW PERSONAL INFORMATION ABOUT INDIVIDUALS ENROLLED INMY CARE MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Privacy Promise

BodySync Physical Therapy LLC understands that your personal information needs to be kept private. Protecting your personal information is important. BodySync PT follows strict federal and state laws that require your personal information be kept confidential.

How I use Your Personal Information:

When you receive services, I may use your personal health information for activities such as providing you with services, billing for services and coordinating care with other providers whom you have given written permission for information to be shared between.

If you have chosen a personal representative and have agreed to let your personal representative obtain your personal health information, I will provide information to your personal representative. If you have a guardian, I will provide the information to your guardian.

You records are kept in a locked file cabinet and/or a locked office. Your records may be store in a computer with HIPPA compliant software only accessible to me. I may receive medical information through mail or fax. Fax transmissions are protected with a confidentiality statement. Your records will be disposed by shredding.

Examples Of How I Use Your Information Without Prior Consent Include:

These are limited situations when I am permitted or required to disclose personal information without your signed authorization. These may include:

- To Protect victims of abuse, neglect, or domestic violence
- To reduce or prevent a serious threat to public health and safety
- For health oversight activities such as investigations, audits, and inspections
- For lawsuits and similar proceedings
- When required by state or federal law
- For specialized government functions such as intelligence and national security

Other uses and discloses not described in this notice require your signed authorization. You may revoke your authorization at any time with written statement.

Your Individual Rights

You have the right to:

- Inspect and receive a copy of your health records including medical and billing notes.

The request should be in writing and a fee may apply.

- Request that information be amended if information is incorrect.
- Request that a specific telephone number or address be used to communicate with you.

Initials_____

- Request restriction or limitation on how your personal information is shared. This must be in writing. This request will be considered carefully, but I am not required to agree wit the request.
- Request a list of disclosed made on or after April 14, 2003 for reasons other than treatment, payment, or reasons provided by law. Your request must be in writing, it should state the period of time desired for the accounting, which must be within 6 years prior to your request. A fee may apply.
- Request additional copy of this notice

File a complaint. If you believe your privacy rights have been violated, you may file a written complaint with:

BodySync Physical Therapy LLC
2908 SW Bridlewood Circle
Lee's Summit, MO 64081

My Privacy Responsibilities

Law requires that I:

- Maintain the privacy of your personal information
- Provide the notice that describes the ways information is used and shared
- Follow the terms of the notice currently in effect

I reserve the right to make changes to this notice at any time and make the new privacy practices effective for all Protective Health Information I maintain. Should the privacy policy change, you will be provided with a revised notice at the address you have supplied.

I give permission to communication through email: YES   NO
Email: ____

I give permission to communicate through text messages: YES   NO
Cell phone: ______________________________________

I give permission to leave voicemails: YES   NO
Phone number: ___________________________________

I, _____________________________, have received a copy of the HIPPPA notification of Privacy Practice by this provider.

_______________________________   _______________________
Patient/ Guardian Signature   Date

Initials_____

BodySync
Physical Therapy