



WILLIAMSTOWN  
PHYSICAL THERAPY

# REGISTRATION FORM

(please print legibly)

<b>A Patient Information</b> <i>If Patient is a Minor ...</i>	<b>Parent/Guardian Information</b>
Patient Name	Parent/Guardian Name
Birth Date	Birth Date
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian
Primary Phone	Primary Phone
Cell Phone	Cell Phone
Email Address	Email Address
Address	Address
City, State, Zip	City, State, Zip
Employer Name	Employer Name
Work Phone	Work Phone
Area of Injury/Pain	

<b>B Physician Information</b>
Referring Physician Name
Primary Physician Name

<b>C Insurance Information</b>																																																							
PLEASE COMPLETE <b>ALL</b> APPLICABLE BILLING INFORMATION BELOW																																																							
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**Note:** If your case involves a **worker compensation claim**, we may be required by law to provide information to your case manager and/or employer. If your case involves a **motor vehicle accident claim**, we will bill **your** auto insurance and may be required by law to provide information to your case manager. Please be aware that you will be responsible for any outstanding balance that may arise from a denial.



**WILLIAMSTOWN  
PHYSICAL THERAPY**

## **FINANCIAL POLICY** *(please read carefully)*

**Thank you** for choosing us as your physical therapy provider. We are privileged to serve you and are committed to providing the best care possible. There are a few things you need to know...

### **Health Insurance:**

We participate in numerous insurance plans. For most insurances, we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, to be personally liable for the balance not covered by insurance. **Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company.** We will work with you to determine the extent of your insurance coverage benefits; however we do not guarantee that your insurance company will pay for services rendered. **We recommend that you contact your health insurance provider to verify your coverage.**

### **Returned Checks:**

A \$25.00 fee will be charged for each check returned to us unpaid by your bank.

### **Cancellation/No-Show Policy:**

In order to schedule patients for the care that they need, and for the consideration of other patients, we require a 24 hour cancellation notice if a patient is unable to make a scheduled appointment time. **If a patient fails to show up for an appointment or to cancel 24 hours in advance, a \$35.00 fee may be charged to the patient for each missed appointment.** After the first missed appointment, the patient must contact the clinic **before** the next scheduled appointment, or all future appointments will be canceled to allow for the accommodation of other patients.

### **Deductibles and Co-Pays:**

**All patient responsibility deductibles and co-pays are due in full at the time of service.** However as a courtesy to you, if you choose to secure your account with a credit card, we will bill you the exact amount your insurance company states is your responsibility once it processes your claims.

### **Please check the one option you prefer:**

**I will pay at time of service.** If my health Insurance does not cover my visits 100%, I will pay an estimated amount of my patient financial responsibility with each visit, based upon verification of my health insurance company's explanation of benefits. I understand that this is just an estimated amount and the actual amount due may be more or less than what is collected. Any overpayment will be refunded upon final processing of all claims.

**Please bill me.** I understand my credit card will be automatically charged for any balance due that is not paid by the due date on my statement. I also understand that if my credit card is due to expire while in treatment, and new credit card information is not supplied before the expiration date, an estimated amount will be applied to my credit card for all past appointments. **Please provide your credit card to the front desk personnel.**

**I would like to discuss a payment plan.**

I have read this **Financial Policy** and I agree to the terms and conditions outlined with in this policy. Furthermore, I agree to assign all health insurance benefits directly to Williamstown Physical Therapy and understand that I am responsible for any costs not covered by my health insurance.

***(Note: If the patient is a Minor (under age 18), a parent or legal guardian must sign this agreement.)***

**X** \_\_\_\_\_  
*Signature of patient, parent or legal guardian* *Date*

Would you like a copy of our HIPAA Privacy Notice?  
*(Please check and initial your preference below)*

No/Refused X \_\_\_\_\_  Yes/Received X \_\_\_\_\_