TENNESSEE THERAPY & BALANCE CENTER
COOKEVILLE, TN

PATIENT REGISTRATION FORM

Today's Date: / / Referring Physician:

PATIENT INFORMATION

First Name: M.I. Last Name:

Date of Birth: / / Age: Sex: M F Social Security #: - -

Address:

Home Phone Number: - - Cell/Other Phone Number: - -

Appointment Reminders: Home Cell Other: - -

Email Address: Occupation: Employer:

Is the condition for which you are referred to therapy related to an auto accident or Workers compensation? YES NO

Are you currently receiving home healthcare? YES NO

Have you participated in [ ] PT [ ] OT [ ] Speech [ ] Chiropractic or [ ] Cardiac/Pulmonary therapy this year? If yes, when was it? YES NO

IN CASE OF EMERGENCY

Emergency Contact: Relationship: Phone:

Disclosures to Family Members and/or Friends: I give permission for my Protected Health Information to be disclosed for purposes of communication results, findings, and care decisions to the family members and others listed below:

1: _____

2: _____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Tennessee Therapy and Balance Center, LLC., hereinafter referred to as "The Clinic". Further, I authorize The Clinic to obtain needed information from my physician, employer, or insurance company.

CONSENT TO TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby consent to the procedures which may be performed during this and future visits that are performed at The Clinic. I/We consent to examination, therapy procedures and therapy care given the patient by or under the supervision of a licensed physical therapist. All Physical Therapists (PT), and Physical Therapist

Assistants (PTA) are employed by The Clinic. The Clinic serves as a medical teaching facility; therefore, physical therapist students, physical therapist assistant students and rehabilitation technicians may be involved in your care under the supervision of an attending PT or PTA.
I understand that no warranty or guarantee has been made to me as to the result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there is a potential risk, although rare, of side effects related to the performance of the physical therapy evaluation and treatment/procedures planned for me.
I hereby consent that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of The Clinic in accordance with the regular rates and terms of The Clinic.
I hereby consent to direct payment to The Clinic of any insurance or other applicable (e.g., Medicare, Commercial Insurance) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services. It is agreed that payment to The Clinic, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. I hereby authorize payment of Insurance benefits to be made on behalf of the patient for all services furnished by The Clinic. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

NOTICE OF INFORMATION PRIVACY PRACTICES

I acknowledge that The Clinic is a healthcare provider who must comply with the Health Insurance Portability and Accountability Act of 1996. HIPAA protects the privacy of individually identifiable health information. I acknowledge that I have been shown the posted Notice of Information Practices by The Clinic, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer, Kimberly Smith, designated on the notice if I have a question or Complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

CANCELLATION AND NO-SHOW POLICY

Our practice is dedicated to helping our patients reach their full recovery potential. It is your responsibility to follow through with your treatment plan and keep scheduled appointments. It is important that you receive the prescribed number of visits that your doctor has ordered and your therapist has planned for you. If it is necessary for you to cancel your appointment, we require 24-hour notice. In the event of a cancellation, please call our office to reschedule that appointment. In the event of repeated no shows or cancellations without proper notice, we reserve the right to charge a $25.00 fee. This is not covered by insurance and will have to be paid by you on your next visit. We appreciate your cooperation and understanding in this matter as we are a small, privately owned clinic.

The undersigned certifies that he/she has read the foregoing and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Patient/Guardian Signature:

Patient Name (print): Date: / /