Life Strength Physical Therapy, Inc.
110 West Road, Suite 105
Towson, MD 21204
Phone 410-321-4901
Fax 410-321-4903

AUTO ACCIDENT/PIP PATIENT REGISTRATION

CONFIDENTIAL PATIENT INFORMATION

The Federal Health Insurance Portability and Accountability Act (HIPAA) established federal guidelines that require Life Strength Physical Therapy to maintain the privacy of your protected health information. The following information is required for our regular business practice and will be maintained in our private records for confidential communication.

Patient Name_____ **DOB**_____ **Sex** _____**SS#**_____
Address_____
City _____ **State** _____ **Zip** _____
Telephone (H) _____ **(W)** _____**(C)**_____
Patient E-Mail Address _____

Marital Status (Please Circle) Single Married Divorced Widowed

Emergency Contact Name:_____**Phone #:**_____

Referring Doctor Name and Phone #:_____

INSURANCE INFORMATION

PIP/AUTO Insurance Company_____
Claim#_____**Date of Accident:** _____
Claim Address: _____
_____
Adjuster's Name:_____ **Adjuster's Phone #:**_____
State where accident occurred: _____

Medical Insurance Company_____
Policy#_____**Group#**_____
Policy Holder_____
Relationship to patient _____ **Policy Holder's SS#**_____
Policy Holder's DOB_____ **Effective Date**_____

ASSIGNMENT OF BENEFITS: I understand that I am responsible for the accuracy of the information on this form. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. If for any reason payment cannot be received from my insurance company(s), I will be held directly responsible for all fees incurred with Life Strength Physical Therapy, Inc., regardless of coverage. I authorize payment of medical benefits to the provider or supplier for all services rendered if the provider of services is a participating provider with my insurance. I also authorize the release of any medical or other information necessary for the processing of claims.

AUTHORIZED SIGNATURE_____**DATE**_____

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Medical Questionnaire

Name:_____Date:_____

Medical History (circle all that apply even if medically controlled)

AIDS or HIV	Dizziness/Vertigo	Kidney Failure	Pregnant
Allergies	Fractures_____	Long Term Steroid Use	Radiation Therapy
Artificial Joint _____	Headaches	Low Blood Pressure	Seizure Disorder
Blackout Episodes	Heart Condition	Metal Implant	Stroke or TIA
Cancer	High Blood Pressure	Osteoporosis	TMJ Dysfunction
Circulatory Condition	Hyperthyroid Hypothyroid	Pacemaker	Visual Impairment
Diabetes	Incontinence	Parkinson's	

Occupation: _____

Reason(s) for which you are seeking Physical Therapy treatment:

List all prior surgeries:

List all current medications:

DRUG NAME	DOSAGE	FREQUENCY AND ROUTE
Example: Aspirin	*81 mg*	**One pill a day by mouth**

List all special tests that have been performed for your condition (i.e. X-ray, MRI, CT Scan):

List all prior physical therapy, chiropractic or osteopathic treatment for this condition:

The information I have provided is correct to the best of my knowledge.

_____ _____
Signature Date

Revised 10/19/18

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FINANCIAL AGREEMENT – AUTO ACCIDENT/PIP

PATIENT NAME: _____

DATE OF BIRTH:_____

_____ (initial) I authorize LSPT to release any pertinent medical information to my insurance companies to facilitate claim processing/payment. I authorize my insurance benefits be paid to Life Strength Physical Therapy, Inc.

_____ (initial) If LSPT is an in-network provider for your medical insurance, we will file your insurance claim for you and collect the co-pay or coinsurance amount at the time of service. If any portion of the charges are not paid by the insurance companies (auto and/or medical), the undersigned will be responsible for payment. Each case can vary in nature and each insurance plan is different. It is **your responsibility** as the patient to read and understand your individual policy.

_____ (initial) I further understand and agree that co-pay and coinsurance amounts will be collected at the time of service and that the undersigned is responsible for such charges. If I am a self-pay, the full amount charged is due at time of service.

_____ (initial) If auto and/or medical insurance coverage is exhausted, you (the patient) accept responsibility for payment of all charges **at the time of service**.

_____ (initial) I understand that it is my responsibility to bring a referral, if required by my insurance, at the time of service. I further understand that if I do not have a referral for services, I am responsible for the full charges of those services. I also understand that in receiving this service without a referral, I am electing to use my out-of-network plan benefit (if applicable). In doing so, I realize that my "out of pocket" financial responsibility may be greater.

_____ (initial) I understand if I fail to pay the charges incurred, a monthly service charge of $2.00 or 1.5% of the total amount (whichever is greater), will accrue monthly and if LSPT must refer the account to a collection agency, that the status of the account may be disclosed to a credit reporting agency, a collection agency, or attorney for the collection of this amount. I also agree to pay all attorney fees, court costs, and collection agency fees incurred.

_____ (initial) I wish to pay for services out of pocket and to NOT have these charges submitted to my insurance carrier.

_____ (initial) I also acknowledge that I am responsible for notifying Life Strength Physical Therapy of any changes in my insurance.

I, _____, have read the above and sign below with my expressed understanding of this Financial Agreement.

_____ _____ _____

Signature-Patient/Guarantor Print Name Date

(Revised 02/01/19)

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Cancellation Policy

At Lifestrength Physical Therapy, our primary goal is to get you better as quickly as possible. You will not help your recovery if you do not make your scheduled appointments. We understand there will be reasons that are legitimate for not showing for appointments so we will be as understanding as possible.

It is our policy to require a **minimum of 24 hours** notice via phone or a message on our answering device to cancel or reschedule any appointments except in the event of sudden emergencies (sickness, severe weather, etc.). Earlier confirmation of a cancellation, if possible, is preferred.

Charges will accrue at **$45.00 per cancellation or "no show"**. The cancellation or "no show" will be charged to the patient's account, not to the insurance company.

After three "no shows" or a pattern of late cancellations, you will no longer be allowed to schedule appointments in advance and will have to call to be worked in when possible.

We appreciate your understanding and thank you for choosing us for your rehabilitation.

_____	_____	_____
Patient or Responsible Party	Signature	Date

(02/01/19)