REGISTRATION

Patient Name _____ Birth Date ___/___/___ Gender _____
Last First Middle

Street Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Phone (H) _____ (C) _____ Driver's Licence # _____
State Number

Occupation _____Employer _____ Phone _____

Responsible Party _____ Relation _____ Birth Date ____/___/____
Last First Middle

Street Address_____ City _____ State _____ Zip _____

Phone (H) _____ (C) _____ Driver's Licence# _____
State Number

Emergency Contact _____ Relation _____
Last First Middle

Address _____ Phone _____

Primary Insurance _____ **Secondary** Insurance _____

***** Please give your insurance cards to receptionist so copies can be made *****

Work injury YES NO Date of Injury _____ Employer @time of injury _____

Auto accident YES NO Date of Injury _____ What state is the claim in _____ Claim# _____

Adjustor Name & Phone # _____ Auto Insurance (Yours) _____

WE DO NOT BILL THIRD PARTY

Please share with us WHO or WHAT influenced you the most to choose us as your Physical Therapist?

*I am a former patient ☐ *Insurance Comp ☐ *Employer ☐ *Attorney ☐

*Clinic Sign ☐ *Website ☐ *Facebook ☐ *Instagram ☐ *Radio ☐ *TV ☐

*Friend / Former Patient _____*Provider _____ Other _____
Name Name

I understand that Alaska Physical Therapy Specialists may need to contact me and I give them permission to leave and /or send a confidential message on the following phone number(s) and/or email:

_____ _____
(email / phone number) *Initials*

The above information is true to the best of my knowledge. I hereby authorize Alaska Physical Therapy Specialists to furnish information to other providers, health care or treatment facilities and my insurance companies for purposes of treatment, payment and health care operations. I hereby assign to the provider all payments for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by my insurances.

X_____ _____

PATIENT / RESPONSIBLE PARTY SIGNATURE **DATE**

Patient Name _____ **Date of Birth**_____

_____ Initial

CONSENT FOR CARE AND TREATMENT

I give my consent to Alaska Physical Therapy Specialists to evaluate my condition and furnish physical therapy treatment as considered necessary and proper by the Physical Therapist.

_____ Initial

CANCELLATION / NO SHOW POLICY

I hereby acknowledge that I have reviewed Alaska Physical Therapy Specialists NO SHOW, CANCELLATION & LATE ARRIVAL policy and I understand a **$50 fee** will be charged to me for each appointment I do not give a **24-hour notice** and/or for each appointment I am **more than 15 minutes late.**

_____ Initial

RELEASE OF MEDICAL INFORMATION *(part 1)*

I authorize Alaska Physical Therapy Specialists to release any medical information about me to my insurance company or worker's compensation carrier for the processing of any medical claims filed on my behalf. I also authorize Alaska Physical Therapy Specialists to release, receive, and/or discuss my medical information with any other medical provider(s) who have, are, or will be participating in my medical care.

_____ Initial

RELEASE OF MEDICAL INFORMATION *(part 2)*

I authorize Alaska Physical Therapy Specialists to speak to the following person(s) regarding my medical care, treatment, and/or billing information: (**name, phone number, and relationship)*

_____

(**names, phone number, and relationships)*

_____

(**names, phone number, and relationships)*

I understand that I have the right to revoke this authorization at anytime.

_____ Initial

DIGITAL IMAGES AND VIDEOS

I understand that photographs and digital videotapes may be recorded to document my care and consent to this. I understand that Alaska Physical Therapy Specialists retains ownership rights to these digital images/videos but I will be able to request a copy. Images that identify me will be released and/or used outside of Alaska Physical Therapy Specialists only upon written authorization from me or my legal representative only if they are released for purposes other than treatment, payment, or healthcare operations.

_____ Initial

PERSONAL PROPERTY:

It is understood that Alaska Physical Therapy Specialists shall not be liable for loss or damage to any personal items brought to physical therapy session during your course of treatment.

I have read, understand, and consent to all the above initialed by me.

X _____

PATIENT / RESPONSIBLE PARTY SIGNATURE **DATE**

PATIENT MEDICAL HISTORY

Patient _____ **Referring Doctor** _____

Work injury? YES NO **Auto injury** YES NO **Date of injury** _____ **Xrays/MRI done?** YES NO

Have you had surgery for this injury? YES NO If Yes, type of surgery**:** _____

List past surgeries: _____

List current medications _____

List any other information that would assist us in your care _____

Are you Pregnant? YES NO Due Date:_____ Use tobacco products? YES NO Frequency:_____

Do you now and/or have you ever had any of the following: *(Circle YES if condition applies to you)*

YES	COPD, Asthma, Emphysema	YES	Shortness of breath	YES	High Blood Pressure
YES	Chest pain, Coronary artery disease	YES	Do you have a Pacemaker?	YES	Allergies
YES	Congestive Heart Failure / Disease	YES	Weight loss / Energy Loss	YES	Stroke /TIA
YES	Epilepsy / Seizures	YES	Weakness	YES	Diabetes
YES	Numbness / Tingling	YES	Vision problems	YES	Hearing problems
YES	Osteoporosis	YES	Sleeping Problems	YES	Arthritis
YES	Increased stress	YES	Severe or frequent headaches	YES	Anemia

YES Emotional/Psychological problems *(explain):* _____

YES Cancer/Chemotherapy/radiation *(explain):* _____

YES Dizziness / Fainting *(explain):* _____

YES Bowel / Bladder problems *(explain):* _____

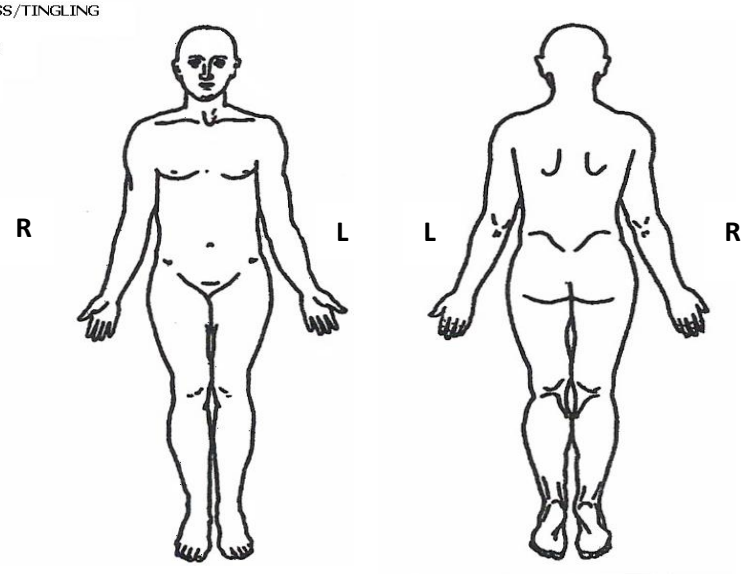
YES Infectious disease *(explain):* _____

YES Blood Clot / Emboli *(explain):* _____

YES Heart attack / surgery *(explain):* _____

YES Pins or metal implamnts *(explain):* _____

↑ SHARP PAIN
\+ NUMBNESS/TINGLING
* BURNING
⬭ ACHING



Please circle your current pain level

1	2	3	4	5	6	7	8	9	10

NO PAIN SEVERE PAIN

X_____ _____

PATIENT / RESPONSIBLE PARTY SIGNATURE **DATE**

FINANCIAL POLICY

- Alaska Physical Therapy Specialists require a copy of any insurance information and phot identification prior to any treatment. If you do not have an insurance card, it is your responsibility to contact your insurance company or your employer and obtain all the necessary information to file a claim for you. Alaska Physical Therapy Specialists will bill your insurance company as a courtesy to you. If your insurance company does not pay the claim within 90 days of the date of service, **the ultimate responsibility for payment and any other account balance is yours, the patient.**

- You are responsible for payment of co-pay at the time of service. If you have not met your deductible, you will be responsible for paying the remaining amount left on your deductible in addition to your co-pay.

- If you have Auto Insurance, we will bill the FIRST PARTY coverage only, if you have a THIRD PARTY Claim, you will be responsible for your entire bill. Please make arrangements to pay for your visit each session

- If you are under Workman's Compensation, it is your responsibility to provide us with insurance information, date of injury, adjuster's name and claim #.

- There is a **$30.00 NSF** charge for **returned checks**. This fee is the patient's responsibility and must be paid before the next date of service.

- Any patient overpayments/refunds will be processed 45-60 days after the final insurance payment has been processed and the final balance has been determined in order to close the patient's financial statement

- If need to make payment arrangements for your account balance, please contact us immediately. Interest rate of 0.875% will be applied after 30 days on any remaining account balances. All delinquent accounts may be turned over to Cornerstone Credit Service for collection.

NO SHOW, CANCELLATION & LATE ARRIVAL POLICY

- A **$50.00 No Show/Cancellation fee** will be charged to you for each missed/cancelled appointment that we did not receive a **24-hour notice.** Patient with more than three (3) cancelled scheduled appointments will be subject for review and discharge from services. This fee is the patient's responsibility and must be paid before the next date of service.

- A **$50.00 Late Arrival fee** may be charged to you if **more than 15 minutes late** for scheduled appointment**.** We reserve the right to reschedule. This fee is the patient's responsibility and must be paid before the next date of service.

NOTICE OF PRIVACY PRACTICES (HIPPA COMPLIANCE)

I have been given a copy of Alaska Physical Therapy Specialists' Notice of Privacy Practices which describes how my health information is used and shared. I understand that Alaska Physical Therapy Specialists has the right to change this notice at any time. I may obtain a current copy in our office, by contacting the Facility Privacy Official, or by visiting our website www.alaskapts.com

My signature below acknowledges that I have reviewed Alaska Physical Therapy Specialists' FINANCIAL POLICY, NO SHOW, CANCELLATION & LATE ARRIVAL POLICY, and I have been provided with a copy of NOTICE OF PRIVACY PRACTICES (HIPPA Compliance).

X

PATIENT / RESPONSIBLE PARTY SIGNATURE **DATE**