ACCELERATE
PHYSICAL THERAPY

CLIENT REGISTRATION FORM

PERSONAL INFORMATION

NAME________________________________ PREFERRED NAME____

ADDRESS/ ZIP CODE (ASSOCIATED WITH INSURANCE)____

BEST CONTACT PHONE NUMBER____

EMAIL ADDRESS____

DATE OF BIRTH____

PRIMARY CARE PHYSICIAN____

PREFERRED METHOD OF COMMUNICATION

- CALL
- TEXT
- EMAIL

PAYMENT OF SERVICES

HOW DO YOU INTEND TO PAY FOR PHYSICAL THERAPY SERVICES?

- INSURANCE (Please provide insurance card to the Client Care Coordinator for Verification of Benefits)
- CASH/CREDIT CARD

REFERRAL INFORMATION

HOW DID YOU FIND US?

- MEDICAL DOCTOR REFERRAL - NAME____
- CLIENT - NAME____
- ONLINE - PLATFORM (e.g. Google, Yelp, Facebook)________________________
- LAW ATTORNEY/OFFICE-____

EMERGENCY INFORMATION (AUTHORIZED PERSON TO CONTACT)

EMERGENCY CONTACT______________________________ PHONE NUMBER_____________________________

NON-INSURANCE

- ❑ I understand that I am choosing to pay out of pocket for my physical therapy treatments. In doing so I agree to pay the Accelerate Physical Therapy non-insurance rate of _$ 65.00_ which will be charged to my card on file at the beginning of each session.
- ❑ Individual Package 6 visits /$60.00--PAID IN FULL
- ❑ Individual Package 12 visits / $55.00-- PAID IN FULL

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INSURANCE

- ❑ I understand that I have a copayment of $________________ that has been appointed by my insurance company. I understand that my copayment is due to Accelerate Physical Therapy at the beginning of my appointment and my card on file will be charged accordingly.

- ❑ I understand that I have a deductible of $______________ that has been appointed by my insurance company. I understand that I will be billed the following rate of $_________ for my evaluation and $_________ for any follow up appointments until that deductible is met. Once my deductible is met, I understand that I will be billed ________% Co-Insurance for every appointment.

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Missed Appointment and Inactive Benefits Policy

- ❑ I understand I will be charged a fee of $50.00 for any appointment not canceled within 24 hours of my scheduled appointment.
- ❑ I understand that if my current insurance fails to pay the contracted rate or is not active during the time of my visit I will pay the daily cash rate of $65.00.

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To ensure convenience, Accelerate Physical Therapy will keep a card on file for every member, regardless of the payment method chosen. Understand that a deductible/coinsurance payment is not due the same day as your appointment, however in order to avoid a large bill at the end of treatment Accelerate offers the following payment methods for those **paying toward their deductible** for your convenience. Please select the method that you wish to be billed:

- ❑ I wish to pay with my card on file the same day of my appointments
- ❑ I wish to set up a payment plan of $__________ which I will be charged with my card on file every _week or month_ (circle one.)
- ❑ I wish to receive a patient statement once my insurance has paid their portion of my Co-Insurance and will call when I receive my statement in the mail to make my payment. Understand that in choosing this option a maximum of 3 patient statements will be sent to the client, if no response is given by the third statement, the card on file will then be charged.

Accelerate Physical Therapy requires a card on file for every client.

Card on file Information:

Card Type____

Card #____

Exp. date:______________________

CVV:_________

Zip Code: ______________________

Client Signature: ____ Date:___________________

CLIENT CONSENT FORM

General Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by or contracted with Accelerate Physical Therapy. I understand that the physical therapist will explain the nature and purpose of the initial evaluation and all procedures and courses of treatment that are recommended for my evaluated condition. The physical therapist will inform me of the expected benefits and complications, any discomforts, and risks that may arise from the recommended treatment, as well as to discuss alternatives to the proposed treatment and additionally the risk and consequences of no treatment.

COVID-19 Information

I acknowledge the contagious nature of COVID-19 and that the CDC and many other public health authorities still recommend practicing social distancing and masking in specified circumstances. I further acknowledge that Accelerate Physical Therapy has put in place preventative measures to reduce the spread of the COVID-19. Furthermore, I acknowledge that Accelerate Physical Therapy can not guarantee that I will not become infected with COVID-19. I hereby release on behalf of myself and any agents, representatives or others acting on my behalf, all causes of action, claims, demands, damages, costs, expenses, and other compensation for damages or loss to myself and/or property that may be incurred following my treatment with Accelerate Physical Therapy. In doing so, I specifically and generally agree to hold Accelerate Physical Therapy harmless.

Assignment of Benefits and Insurance Proceeds

I authorize payment of medical billings directly to Accelerate Physical Therapy for services rendered. Accelerate Physical Therapy will make all reasonable efforts to collect insurance proceeds by completing insurance forms and filing them with the responsible insurance company.

It is understood that completion of such forms and/or the acceptance of assignment of insurance benefits do not relieve the undersigned of the obligation to provide accurate patient and insurance information as well as the overall obligation to pay the amount owed for physical therapy services.

Patient Information Consent Form (HIPAA)

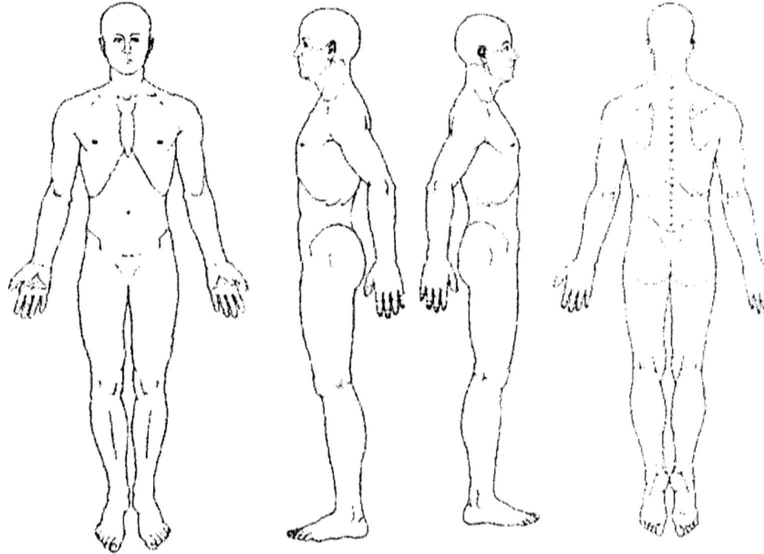
I have read and fully understand Accelerate Physical Therapy's Notice of Information Practices. I understand that Accelerate Physical Therapy may use or disclose my personal health information for the necessary specific purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payement, and administrative operations. I also understand that Accelerate Physical Therapy will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests.

Release of Information

I hereby authorize the release of information necessary to file a claim with the insurance company.
In addition, I authorize Accelerate Physical Therapy to use such information to make a referral for additional medical services concurrently or additional to services provided by them.
I permit a copy of this authorization to be used in place of the original.

Client Signature x:____ Date x:________________________________

1. Please shade in the areas you experience pain and/or symptoms.



2. From 0-10 (0 = no pain and 10 = worst pain imaginable) please rate your symptoms.

   Best: 0 1 2 3 4 5 6 7 8 9 10

   Current: 0 1 2 3 4 5 6 7 8 9 10

   Worst: 0 1 2 3 4 5 6 7 8 9 10

3. Please list past surgical intervention, medications and medical history your physical therapist should know about.

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4. Please circle yes or no to answer the following questions.

Shortness of breath with exertion	Yes / No	History or current treatment of cancer	Yes / No
Hypertension (with or without medication)	Yes / No	New onset altered sensation in arms/legs	Yes / No
Dizziness/lightheadedness	Yes / No	Fever over 100 F	Yes / No
Unexplained weight loss/gain	Yes / No	Changes in bowel/bladder function or urgency	Yes / No
Unexplained pain at night	Yes / No	Weakness or dropping objects	Yes / No
Relief of symptoms with rest	Yes / No	Saddle numbness	Yes / No