15201 Shady Grove Road, Suite 106, Rockville, MD 20850 Phone: 301-948-4395 Fax: 301-407-1860
12800 Middlebrook Road, Suite 100, Germantown, MD 20874 Phone: 301-235-3031 Fax: 240-702-0074

Registration Form

Note: Please print to complete or complete using the fillable option. Paperwork for patients under the age of 18 must be completed and signed by a parent/guardian.

Patient Name (Last, First, Middle Initial): _____ **Date of Injury:** ____/ ____ /____

Social Security #: _____ Date of Birth: ____/ ____ /____ **Cause of Injury (check one):** Age: _____ Sex: Male □ Female □ Marital Status: _____ □ Auto Accident Guardian's Full Name (If patient is a minor): _____ □ Workers Compensation Guardian Date of Birth: ____/ ____ /____ □ Other: _____ Address: _____

City: _____ State:_____ Zip: _____ Home Phone #: _____Cell Phone #: _____ Email: _____

Referring Physician: _____ Primary Care Physician: _____

How did you hear about us?: _____

Emergency Contact & Relationship: _____ **Phone #:** _____

Consent for Treatment of a Minor

As a parent and/or legal guardian, I authorize the office/facility to treat the patient while I am not present. Patient Name: _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Office Policy for No Shows/Cancellations, Returned Checks, and Insurance

We realize circumstances might lead to a missed appointment. However, in order to provide the best care and service to each patient, we ask that you notify us **24-hours in advance** to cancel your appointment unless scheduled on Saturday. On Saturdays, we ask that you notify us 48-hours in advance to cancel your appointment. We will be more than willing to reschedule your appointment for a different time on the scheduled day or within the same week.

Failure to properly notify the office/facility may result in a fee of $75.00 for the no show and/or cancellation. There is also a $25.00 fee for all returned checks.

Insurance is considered a method of reimbursement for patients for fees paid to the doctor/therapist and is not a substitute for payment. Some insurance companies may pay fixed allowances - sometimes referred to as "reasonable and customary fees" - for certain procedures. We do not accept this as payment in full unless otherwise restricted by law or according to the agreement that we may have with your insurer. Also, some insurance companies pay only a percentage of the charge. It is your responsibility as a patient to pay any deductible, co-insurance, or other balance amount not paid by your insurer. In order to manage your cost of billing, we request that charges for visits be paid in full at the onset of the next visit. In the event that the account is turned over for collection, the collection fees and/or legal fees, including attorney fees, shall be your responsibility.

I hereby assign all medical and/or surgical benefits including major medical benefits to which I am entitled (i.e., Medicare, private insurance and other health plans) to the office/facility listed on the top header of this page. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary to secure the payment via fax transmittal or paper copy.

Patient or Parent/Legal Guardian Signature: _____ **Date:** _____

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Assignment of Benefits

I hereby instruct and direct _____ (insurance company) to pay by check made out and mailed to the office address. If my current policy prohibits direct payment to this practice, I hereby also instruct and direct you to make the check to me and mail it to the office address.

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered, this is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A copy of this assignment shall be considered as effective and valid as the original. I authorize the release of any information pertinent to my case to any insurance company or adjuster involved in this case. I authorize FYZICAL Therapy & Balance Centers to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Practices

Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, be kept confidential. This includes the following:

- Treatment
- Payment
- Health Care Operations
- Marketing Activities

A copy of this policy is available to you at your request. In addition, there is a copy displayed in the lobby area of the office/facility to be reviewed.

Patient Signature: _____
Date: _____

Telehealth Informed Consent

I voluntarily agree to receive telehealth services for new and/or existing care and treatment. I authorize FYZICAL Therapy & Balance Centers to provide therapy services considered medically necessary and advisable for my case. I may experience an increase in current symptoms or aggravation to my existing injury or condition. I may withdraw my consent for virtual visits at any given time or my provider may discontinue virtual visits when telehealth services are not medically necessary or advisable for the situation. I understand the risks for using telecommunication technology, including interruptions, unauthorized access, and technical difficulties. I understand that I am responsible for maintaining confidentiality of identifications and passwords as well as limiting access to my computer and/or phone so that others may not access this service on my behalf. I further understand that I am responsible for using this technology in a secure and private location so that others may not overhear my conversation with my provider. I understand that there will be no recording of the virtual visit and disclosure of health information from written records regarding my virtual visit without my consent.

Patient Signature: _____Date: _____