MARQUETTE PHYSICAL THERAPY, P.A.

PATIENT REGISTRATION

33255 Lexington Ave.
Suite A
DeSoto, KS 66018
913.585.9844(P)
913.585.9841(F)

13430 Briar Dr.
Suite C
Leawood, KS 66209
913.484.7632 (P)
913.808-5460 (F)

Patient Name: _____
First MI Last

Address: _____

City: _____State:_____ZipCode:_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Marital Status: _____

Email Address: _____

Employer: _____ Work Phone: _____

Referring Physician: _____ How did you hear about us? _____

Emergency Contact: _____ Relation: _____ Phone: _____

Primary Insurance: _____ Secondary Insurance: _____

1. What is your chief complaint/area of pain? _____
   What date did problem begin? _____

2. Is your condition related to an Accident for which you are holding someone else responsible? Y N
   Type of Accident: _____Date of Accident: _____

3. Have you had any other Physical Therapy or Chiropractic care this year? Y N
   How many visits? _____

4. Has the front office discussed self pay options with you regarding your PT visits? Y N

I certify that the information above is true and correct to the best of my knowledge. I understand and agree that regardless of my insurance status I am ultimately responsible for the balance on my account for any professional service rendered. I also understand that by signing this form, I am giving consent for treatment by Marquette Physical Therapy, PA, and a physical therapy diagnosis is not a diagnosis by a physician.

Patient Signature: _____ Date: _____

Authorization

I authorize Marquette Physical Therapy, PA to release any information acquired in the course of my treatment necessary to process insurance claims or to discuss my treatment with other practitioners by fax, email and/or mail.

I understand these records will be used for the purpose of rehabilitative therapy and will be kept confidential.

I authorize benefits to be paid on my behalf to Marquette Physical Therapy, PA for physical therapy treatment.

I am aware that **I am responsible for deductibles, co-insurances, co-pays and any non-covered services**.

Patient Signature: _____ Date: _____

Privacy Notice

By signing this form, I acknowledge that Marquette Physical Therapy, PA has provided me with a copy of its Privacy Notice, which explains how my health information will be handled in various situations. If I have questions or concerns regarding this Privacy Notice I will contact a Marquette Physical Therapy, PA representative.

Patient Signature: _____Date: _____

Medicare

I authorize the Centers for Medicare and Medicaid (CMS) to make payment on my behalf to Marquette Physical Therapy, PA for services provided to me by Marquette Physical Therapy, PA.
I am aware that Medicare has a yearly cap allowance for physical and occupational therapy of $1980. I understand that I will be referred back to my physician if I were to near that cap allowance so as to come up with an appropriate plan of treatment.

Patient Signature: _____

Medicare ID # : _____ Date: _____

PLEASE READ THIS PAGE CAREFULLY

By signing Below:

I **understand** that my insurance company does NOT view any correspondence with this medical provider's staff as a promise to pay, and thus quoted benefits are an ESTIMATE ONLY. This means the insurance company pays the claim, I may have a refund coming or I may owe additional fees such as copays, deductibles and/or coinsurance.

I **understand** that I am responsible for any amount not paid by my insurance company, regardless of the estimate I receive as to my portion of the bill.

I **acknowledge** that I have been given the opportunity to ask questions of the medical provider's staff concerning billing and I have had/will call my own insurance company regarding my physical therapy benefits and payment of such claims.

Patient Signature: _____ Date:_____

CANCELLATION FEE:

I understand that Marquette Physical Therapy, PA requires **24 hour** notice in the event of a cancellation. While certain unforeseen circumstances (illness) may prevent a full 24 hour notice, I agree to give as much notice as possible.

I understand that there is a **$50 charge** for a no show or a cancellation without proper notice. This is NOT covered by insurance- I am responsible to pay this before my next scheduled appointment.

In the instance of repeated no shows or cancellations without proper notice I understand that Marquette Physical Therapy, PA reserves the right to cancel all future appointments and alert the referring physician of non compliance if applicable.

Patient Signature: _____ Date:_____

Request for Electronic Access and Authorization for Email Communication

Name:_____

Email:_____

I authorize Marquette Physical Therapy, PA to contact me using the email address provided above included my name, information regarding my account balance and instructions for accessing the patient portal.

I understand that:

- The information is being sent for the purpose of communicating with me and allowing me to set up an account to access the patient portal
- My name and account balance could be viewed by anyone who has access to my email and that if my email is unsecured, the information could potentially be intercepted PLEASE NOTE: The patient portal is secure and is only accessible to someone who has the answer to certain questions that are expected to be known only to me
- This authorization will be in force and effect until I revoke the authorization by making a request in writing to:

  Marquette Physical Therapy, PA
  ATTN: Privacy Officer
  13430 Briar St. Suite C
  Leawood, KS 66209

I further understand that:

- Information used or disclosed pursuant to this authorization (name, email, practice name and account balance) may be used by a recipient of the email communication and then will no longer by protected by federal or state law
- I can refuse to sign this authorization and the practice will not condition my treatment on whether I sign
- I have the right to inspect or copy my protected health information as permitted by federal and state laws

Name: ____ Date: ________________