bodyworks
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

3161 43rd St S
Fargo, ND 58104
Phone: (701) 893-2639
Fax: (701) 893-2638
www.bodyworksfargo.com

Patient Name: (print) _____ Date of Birth: _____ Age: _____
First Name, MI, Last Name

Responsible Party: (if minor) _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: ( ) _____ Home Phone: ( ) _____

Social Security Number: _____ E-mail Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: ( ) _____ Alternate Phone: ( ) _____

Reason for Visit: _____ Referred By: _____

Have you had physical therapy treatment within the last calendar year? YES NO if so, how many visits? _____

PATIENT EMPLOYMENT INFORMATION

Employed: Full-time Part-time Retired Unemployed Disabled Student: Full-time Part-time

Employer: _____ Occupation: _____

Address: _____ Business Phone: ( ) _____

City: _____ State: _____ Zip: _____

PATIENT BILLING & PAYMENT INFORMATION

Method of Payment (check all that apply, we will scan your current insurance card(s) into our computer system):

❑Cash ❑Private Health Insurance ❑Medicare ❑Secondary Insurance ❑Medicaid ❑TriCare/Champus

***PLEASE SPECIFY CARD HOLDER'S NAME: _____ Date of Birth: _____ ***

❑ Workforce Safety Insurance ..... Claim Number: _____

❑ Other..... Specify: _____

PATIENT FINANCIAL POLICY FOR BODYWORKS PHYSICAL THERAPY

- I have presented a valid insurance card to *Bodyworks Physical Therapy*. If my insurance changes or is updated, I will notify *Bodyworks Physical Therapy* as needed.
- We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due at the time you check in for your appointment. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.
- Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CMS. If your secondary insurance does not crossover, we may have you file the claim. As a courtesy, we will provide you with a claim form that you can then send to your insurance carrier. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non covered service will be due as service is rendered.
- Medicaid: Our office is a NDMA and MNMA participating provider and we will bill Medicaid for you. Any outstanding balances, co-payments and deductibles are due prior to your appointments.
- Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit to bill the worker's compensation insurance company.
- Auto Insurance: If your visit is due to injuries sustained in a car accident and you plan on submitting it to your auto insurance, we will need your policy, claim number and address to submit your claim to.
- I hereby assign all insurance benefits (or services rendered to which I am entitled) to *Bodyworks Physical Therapy*. I realize that if my third-party payer/insurance company denies my charges or makes partial payment, that I am responsible for the balance and any late fees incurred.
- Methods of Payment: Our office accepts cash, personal check, Visa, Mastercard & Discover Credit Cards and patient financing options may be available in some cases.
- Returned Checks: We assess a $25.00 NSF charge and report to the local district attorney's office, checks that are not paid within 2 weeks of being returned to our office.
- If not paid according to terms, I understand that *Bodyworks Physical Therapy* reports to an outside collection agency. In the event that your account is turned over for collections, I agree to pay all additional fees accessed in the collection of the dept. These fees include collection agency fees and attorney fees.
- Cancellations/No-show for your appointment: If you are unable to keep a scheduled appointment, we require a 24-hour notice or you may be charged a $25.00 fee. This CANNOT be billed to your insurance and is the patient's responsibility.
- The patient (guardian) is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

_____ ***Date:*** _____

Patient/guardian signature