GAINESVILLE PHYSICAL THERAPY
NEW PATIENT REGISTRATION

****PLEASE PRINT CLEARLY AND FILL IN ALL INFORMATION****

HOW DID YOU HEAR ABOUT OUR CLINIC?

Doctor ____ (name) _____ Family Member ____ (name) _____Friend _____ (name) _____
GPT STAFF MEMBER_____ (name) _____Website_____ Ad _____Complimentary Coupon _____Insurance Co. _____

PATIENT INFORMATION

Last Name_____First Name_____ MI_____

Date of Birth_____ Sex M / F Social Security Number _____

Home Address_____City_____State_____Zip Code_____

Mailing Address_____City_____State_____Zip Code_____

Home Phone _____Work Phone _____Cell Phone _____ Other_____

Emergency Contact Name_____Relationship_____Phone_____

Would you like an appointment reminder? If yes, please check one Text_____ Voicemail_____

Email Address _____

Marital Status: Single ( ) Married ( ) Divorced ( ) Legally Separated ( ) Widowed ( )

Student Status: Full Time ( ) Part Time ( ) Non Student ( ) Employment Status: Not Employed ( ) Full Time ( ) Part Time ( ) Retired ( )

Employer / School Name _____

Employer / School Address_____Employer Phone _____

PHYSICAN INFORMATION

Referring Physician Name_____ Physician Phone _____

WHAT ARE WE TREATING TODAY? (Briefly describe) _____

Illness? _____ (date of first symptom) _____ OR Injury? _____ (date of injury) _____

Work Related? Yes ( ) No ( ) Accident related? Yes ( ) No ( ) How ?: Car ( ) Home ( ) Other Accident ( )

***Name and Phone Number of Adjuster/Case Manager or Lawyer (required)**_____
Claim number **(required)**_____

INSURANCE INFORMATION

Primary Insurance Co _____ Policy Holder_____

Policy Holder Date of Birth _____Policy Holder Social Security # _____Relationship_____

Secondary Insurance Co _____ Policy Holder _____

Policy Holder Date of Birth _____Policy Holder Social Security #_____Relationship_____

GAINESVILLE PHYSICAL THERAPY
1296 SIMS STREET, SUITE A
GAINESVILLE, GEORGIA 30501

PHONE: (770) 297-1700
FAX: (770) 297-1702

RESPONSIBLE PARTY STATEMENT

As the Responsible Party, I agree that all charges that are not directly paid by my insurance company will be MY RESPONSIBILITY.

Signature of Responsible Party _____ **Date** _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Gainesville Physical Therapy in the event they file insurance on my behalf. A copy of this assignment shall be considered as effective and valid as the original.

I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default in payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt, including but not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for the unpaid balances over 90 days old.

I hereby authorize said assignee to release all information necessary to secure payment of said benefits. I understand I may need to complete and return additional forms from/to Gainesville Physical Therapy according to governing laws and policies of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I do hereby consent to such treatment by the authorized personnel of Gainesville Physical Therapy as would be dictated by prudent medical practice/treatment of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature _____ **Date** _____

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PRIVACY POLICY

WE AT GAINESVILLE PHYSICAL THERAPY WILL NOT RELEASE ANY INFORMATION ABOUT YOU TO ANYONE OTHER THAN YOUR REFERRING PHYSICIAN OR YOUR INSURANCE COMPANY WITHOUT YOUR WRITTEN CONSENT.

By signing below, I acknowledge that I have read and understand Gainesville Physical Therapy's Privacy Notice.

_____
Printed Name of Patient or Patient's Representative

_____ _____
Signature of Patient or Patient's Representative Date

_____
Representative's Relationship to Patient (if applicable)

To be completed by Gainesville Physical Therapy Staff

Are there any Privacy Issues?

Office Staff → Please Initial Yes or No

_____ NO

_____ YES

*If "YES" please have patient complete appropriate Patient's Rights Form(s) and place in patient's chart

Clinical Staff → Please Initial YES or NO

_____ NO

_____ YES

****

- After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

_____

_____

_____

_____ _____
Signature of Gainesville Physical Therapy Representative Date

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize the release of any medical information, records and reports, including copies of x-rays and photo static copies, abstracts of excerpts of all records and any other information to Gainesville Physical Therapy, LLC.

Patient's Name (printed)_____ Date of Birth_____

Patient's Signature_____ Date_____

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To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions, and we will be able to help you achieve your goals in treatment.

- We require 24 hours' notice in the event of a cancellation. It is your responsibility when you call in to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- There is a $25 charge for a cancellation without proper notice. This charge will not be covered by insurance but will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician, and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you do rearrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.
- When you don't show as scheduled, three people are hurt: You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in his/her schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We're looking forward to working with you.

_____ _____

Patient Signature Date

_____ _____

Interviewer Signature Date

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Thank you for choosing Gainesville Physical Therapy

Have you or a family member been to Gainesville Physical Therapy before?

YES_____ NO_____

The greatest compliment we can receive is a referral from one's friend or family.
Who may we thank for your visit today?

FAMILY MEMBER_____

FRIEND_____

EMPLOYEE AT GPT_____

DOCTOR_____

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MEDICATION LIST

(IF YOU HAVE A LIST, WE CAN COPY IT FOR YOU)

Patient name_____

Name of Medication	Dosage

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ATTENTION ALL NEW PATIENTS:

THE FOLLOWING SUPPLIES MAY BE SUGGESTED TO GO ALONG WITH YOUR TREATMENT IN THE FUTURE. IT IS YOUR CHOICE WHETHER YOU WOULD LIKE TO PURCHASE THESE ITEMS. THE FOLLOWING IS A LIST ALONG WITH THE PRICES. PLEASE ADD TAX. THESE ARE **NONRETURNABLE** AND **NONREFUNDABLE** SO MAKE SURE YOU CAN WEAR AND USE THE SUPPLIES BEFORE YOU BUY THEM.

TREAT YOUR OWN BACK BOOK $15.00

TREAT YOUR OWN NECK BOOK $15.00

LOW BACK PAIN/SI JT BOOK $24.95

SHOULDER BOOK $16.95

POST SURGERY LUMBAR REGION BOOK $16.95

THERABAND $4.00 THERAPUTTY $5-10.00

TAPING KIT FOR BACK $67.00

SI BELT/LUMBAR BRACE $60.00-70.00

PAIN CREAMS $12.00-40.00 DEPENDING ON SIZE

POSTURE BRACE $40.00

BACK PILLOW (BLOW-UP) $25.00

SIGN HERE ***x***_____ ***DATE*** _____

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ATTENTION ALL PATIENTS:

IF YOU ARE PAYING WITH A CREDIT CARD, THERE IS NOW A *3.5%* SURCHARGE, ADDED BY THE BANK.

THIS CHARGE APPLIES TO ALL CREDIT CARDS. HOWVER; IT DOES NOT APPLY TO DEBIT CARDS.

YOU'RE WELCOME TO USE DEBIT, CASH, OR CHECK TO AVOID THIS FEE.

WE ARE SORRY FOR ANY INCONVENIENCE.

SIGN HERE ***x***_____ ***DATE*** _____