Confidential Registration Form

Name:_____ Today's Date: _____/_____/_____

Date of Birth _____/_____/_____ SS#:_____-_____-_____ Phone: _____

Email: _____ Work or Cell: _____

Address:_____ City: _____ State: _____ Zipcode:_____

Sex: M or F Marital Status: S M D W Other Student: Y or N School: _____

In Case of Emergency Please Contact: _____ Phone#: _____

Primary Insurance Company: _____ Subscriber ID: _____

Policy Holder _____ Date of Birth _____/_____/_____ SS#:_____-_____-_____

Relation to Patient:_____ Address:_____ City: _____State: _____ Zip:_____

Secondary Insurance: _____ Subscriber ID: _____

Attendance Policy

- A cancelled visit will be recorded if the Gait Center receives notification at least 24 hours in advance of appointment. There is no charge for cancelled visits.
- Notification less than 24 hours will be considered a missed visit. After 2 missed visits the patient will be charged a $25 fee for each additional missed visit. This amount will be due at the next scheduled visit.
- More than 6 cancellations or missed visits will be cause for review of the rehabilitation commitment and possible discharge from physical therapy services at The Gait Center.

Reminder Notifications: The Gait Center will contact you the day before your appointment.

What is your preferred method of contact for reminder notifications? (please check one)

□ Phone call □ Email □ No Reminder Please

Payment Agreement: (To be completed by The Gait Center)

Your insurance provider has informed us that you have:

□ _____ Co-Pay for therapy

□ _____ Co-Insurance

□ _____ Deductible to be met (patient responsible for the allowable charges)

This is not a guarantee of coverage. It is the patient's responsibility to confirm benefits directly with their insurance company, and monitor "Explanation of Benefits" sent to them from their insurance company.

This amount is due prior to therapy services on each visit. Any remaining balance will be invoiced to the patient on a monthly basis. ___/___/___, _____ (Gait Center Personnel)

NOTES:

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to The Gait Center regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred. I acknowledge that I have seen the "Notice of Privacy Practices," and understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ **Today's Date:** _____/_____/_____