Patient information

Patient full name: _____

Patient preferred name:_____

Date of Birth:_____ Today's date:_____ Gender:_____

SSN:_____Cell phone:_____Home phone:_____

Patient mailing address:_____

_____

Email:_____Preferred method of contact:_____

How did you hear about us?_____

If the patient is a minor or cognitively impaired, please proceed to completing the next section.

Sponsor full name: _____

Date of Birth:_____ Today's date:_____ Gender:_____

Cell phone:_____Home phone:_____

Sponsor mailing address:_____

_____

Email:_____Preferred method of contact:_____

Patient primary care physician:_____

Referring physician:_____

Emergency contact: 1._____ relationship/phone #:_____

2._____relationship/phone #:_____

3._____relationship/phone #:_____

Insurance

Primary Insurance:_____ Name of policy holder:_____

Address of policy holder, if different than patient:_____

_____

Policy number:_____Group number:_____

Group name:_____Date of birth of policy holder:_____

If applicable, please complete the following section:

Secondary Insurance:_____ Name of policy holder:_____

Address of policy holder, if different than patient:_____

_____

Policy number:_____Group number:_____

Group name:_____Date of birth of policy holder:_____

Authorization and Assignment: I directly assign all medical benefits to Enhanced Therapy Services and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize Enhanced Therapy Services to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

I understand that failing to communicate any changes in insurance throughout treatment may result in incorrect insurance filing, and therefore, leave the patient responsible for any/all accrued balance. I consent to the care and treatment of myself (or this patient) by the attending provider and/or his or her associates and assistants. In the case that the patient is not myself, I attest that I am the parent or legal guardian of this patient.

Signature:_____Date:_____

Express Prior Consent to Contact Consumer:

In the event that it becomes necessary to collect any amounts owed by you, you agree that Enhanced Therapy Services and/or third party agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial messages and/or use of automatic dialing device, as applicable

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

I hereby authorize any physician or hospital to provide copies of my medical history and treatment to Enhanced Therapy Services, as pertinent to my care. Photocopies of this agreement are valid as the original. I have read this entire Patient Registration form and agree to all provisions of this form, including but not limited to the Authorization and Assignment provisions and the Consent to Contact Provisions.

Signature:_____Date:_____

Health History

Please list any/all current medications:_____

_____

Allergies:_____

Surgical history:_____

_____

Please indicate all that apply.

Condition	X	**Condition**	X	**Condition**	X
Acid Reflux/Gerd		Alcoholism		Autism	
Gastrointestinal Disorders		History of Pneumonia		Developmental delay	
Asthma		Tinnitus		Seizures	
COPD		Vertigo		Blood Clots	
Cancer		Arthritis		Stroke	
Heart Attack		Diabetes		Hearing deficits	
High Blood Pressure		Stomach Ulcers		Vision impairment	
Kidney Disease		Parkinson's disease		TBI	
Alzheimer's and/or dementia		Other neurologic disorders		Intellectual Disabilities	

If not listed, please specify: _____

_____

Our goal is to provide and maintain a good provider-patient relationship. By informing you in advance of some of our policies, it allows for good communication and enables us to achieve our goal. Please read each section carefully. If you have any questions, please do not hesitate to ask a member of our staff.

HIPAA POLICY:

1. We are concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

2. Your health care provider and members of the staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives or other health related information that may be of interest to you.

3. You may restrict the individuals to which your health care information is released.

Please complete the below chart as to whom you authorize to receive your health information:

1. Name:	Relationship:	Telephone Number:
2. Name:	Relationship:	Telephone Number:
3. Name:	Relationship:	Telephone Number:

The following information may be disclosed to the above mentioned name(s)
(Please check all that apply):

□All Information □ResultsOnly □Appointment Status

Protected Health Information may be disclosed via
(Please check all that apply):

□Home Voicemail □Mobile Voicemail □ Work Voicemail □Email

Signature: _____Date:_____

Media release

We love to show our patient's progress and what we do at Enhanced Therapy Services. Please be advised that during treatment sessions patients may be photographed or videoed. With your consent, the photos or video may be released for the use of Enhanced Therapy Services.

Yes_____

No_____

Signature:_____Date:_____

Cancellation/No show Policy- Please read carefully

At Enhanced Therapy Services, we value the time we have set aside to treat all of our patients. We make a great deal of effort to provide each patient with one-on-one, individualized care. Therefore, Enhanced Therapy Services reserves the right to charge a fee of $75 for all missed appointments ("no shows"), and appointments in which the patient is absent without a 24 hour notice. We understand life happens, however, each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.

"No show" and late cancellation fees will be automatically billed to the patient and are not covered by insurance. These fees may also be requested to be paid before rescheduling. Patients will be allowed to schedule/reschedule the initial evaluation a total of two times before being moved to the end of the waitlist. 3 "no shows" or unnecessary late cancellations within a 3 month period may result in termination from therapy services. Although we do provide a reminder system as a courtesy to our patients, patients are responsible with keeping up with their appointments. Cancellations over the "reminder" system for instances that are known in advance, i.e. vacations, other appointments, family conflicts, and prolonged sickness are not acceptable. Please let us know as soon as you realize you cannot make an appointment.

Thank you for your understanding and cooperation as we strive to best serve our patients.

Signature:_____ Date: _____

Is the patient currently receiving, or plans to receive, any form of Home Health services?

Circle one: YES NO

If yes, please let our receptionist know when turning in your paperwork. Receiving Home Health Services excludes the patient from being eligible for insurance coverage for our services.