ONONDAGA PHYSICAL THERAPY
helping you live, work and play better

Registration Form

(Please Print Clearly)

PATIENT INFORMATION

TODAY'S DATE: / / PRIMARY CARE PHYSICIAN:

Patient's Last Name	First	Middle	What would you prefer to be called?

Street Address	City	State	Zip Code

Home Phone	Work Phone (extension)	Cell Phone	Sex	Age	Date of Birth
			□ Male □ Female		/ /

Email Address:	How would you like us to keep in touch with you? □ Email □ Postal Mail

Marital Status	**Employment Status**	**Accident?**	Date Of Next Physician Appt
□ Single □ Married □ Widowed □ Divorced	□ Full □ Part □ Retired □ Not Employed □ Other	□ None □ Auto □ Work □ Other	/ /

INSURANCE INFORMATION (Please Show Your Insurance Cards)

Primary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

Secondary Insurance	Policy Holder Name	Policy Holder DOB	Insurance Card ID #	Group #

Patient Relationship To Policy Holder: □ Self □ Spouse □ Child □ Other_____

If Patient is a Child, please provide the name and address of the guarantor whom should receive any statements from us:

Full Name:_____ Billing Address:_____

IN CASE OF EMERGENCY

Contact Name	Relationship To Patient	Home Phone	Cell Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Onondaga Physical Therapy, LLC. I understand that I am financially responsible for any balance that is unpaid by my insurance company. I understand Onondaga Physical Therapy will impose a late fee of $25 for any balance that is older than 90 days, unless I have prior payment arrangements. I further authorize Onondaga Physical Therapy, LLC and my insurance company to release any information that is required to process my claims.

I hereby consent to treatment procedures and patient care which in the judgment of my therapist and/or physician may be considered necessary or advisable while I am a patient of Onondaga Physical Therapy, LLC.

I hereby authorize the use or disclosure of my individually identifiable health information as described in the NOTICE OF PRIVACY PRACTICES I received.

X_____

PATIENT/GUARDIAN SIGNATURE Printed Name DATE

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Medical History Form

(Please Print Clearly)

Name:	Date:

Have you EVER been diagnosed as having any of the following conditions?

Yes No Heart Problems	Yes No Epilepsy / Seizures	Yes No Implanted Devices
Yes No High Blood Pressure	Yes No Hearing Loss / Disorder	Yes No Cancer
Yes No Pacemaker	Yes No Eye Disease	Yes No Osteoporosis
Yes No Rheumatoid Arthritis	Yes No Muscular Disease / Disorder	Yes No Depression
Yes No Other Arthritic Condition	Yes No Multiple Sclerosis	Yes No Past Pregnancy
Yes No Stroke	Yes No Tuberculosis	Yes No Currently pregnant
Yes No Lung Disease	Yes No Circulation Problems	Yes No Chemical Dependency
Yes No Asthma	Yes No Hepatitis	Yes No **Latex Allergy?**
Yes No Diabetes	Yes No Kidney Disease	Other (Please List):

Please list any surgeries or other medical conditions for which you have been treated

Date	Surgery/Injury/Condition	Reason:

List all medications you are currently taking (pills, injections, inhalers, skin patches):

Please list any known and diagnosed allergies and any additional comments or information you would like us to know:

X _____

PATIENT/GUARDIAN SIGNATURE DATE

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HIPAA Privacy Information

TODAY'S DATE: / /

PATIENT INFORMATION

Patient's Last Name First Name Date of Birth

CONTACT METHODS

Please check the appropriate boxes indicating acceptable ways for us to contact you regarding either your appointment(s) or other medical information. By checking these boxes, you give us permission to contact you and/or leave messages.

Appointment Information

- □ Home Phone
- □ Mobile Phone
- □ Mobile Text**
- □ Work Phone
- □ With another person:
- □ Send Via Mail
- □ Send Via Email

Medical & Billing Information

- □ Home Phone
- □ Mobile Phone
- □ Mobile Text***
- □ Work Phone
- □ With another person:
- □ Send Via Mail
- □ Send Via Email***

**Checking Mobile Text will enroll you in Text Message Appointment Reminders, automated reminders delivered the night before your schedule appointments. Carrier messaging rates may apply per your plan.
***Checking Mobile Text and Email boxes for Medical & Billing information will allow our billing department to communicate with your regarding your insurance coverage and deliver electronic billing statements and balance information to you by text and email.

If you have authorized us to communicate medical or appointment & billing information with another individual, please provide their name and relationship:

Name: _____ Relationship: _____

AGREEMENT INFORMATION

I have read the above information and have authorized Onondaga Physical Therapy to relay appointment or medical information in the manners I have specified above.

X_____

Patient Signature Date

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Attendance Policy: 24-Hour Notice Required

Avoid a Fee! Send a **TEXT MESSAGE or PHONE CALL to (315) 635-5000** greater than 24-hours in advance to Cancel/Change an appointment ***OR*** Meet with your therapist virtually via Telehealth.

We have reserved these times to care for you. **You are expected to arrive on time to all scheduled appointments** or give 24-hour notice to cancel or change a scheduled appointment. If your **personal or work schedule** might affect your ability to keep an appointment, *please don't schedule until you are certain you can keep your time*. We are sensitive to the fact that an emergency may occur in rare instances and do offer 1 cancellation per month as a courtesy.

Please be considerate of our other patients. We maintain a WAITING LIST so that we can offer open appointments to *other patients waiting to be treated.* For this reason, if you do not give adequate notice & allow us to care for another patient instead, you will be charged for the missed appointment. **This includes late arrivals.** If you arrive more than **10 minutes late,** you will be considered a "no show." **If you fail to show for an appointment** without speaking to our staff, we will call/text you to remind you of your next appointment. If you do not confirm by the next morning, we will **delete all future appointments** to open up opportunities for other patients. You will need to contact us to schedule further appointments. **Upon third violation of this policy by late cancel/no show,** you will be put on a scheduling limitation of 24 hours in advance, or our "24 Hour List" which means that at the time you call to request an appointment, you will only be offered available appointments within 24 hours of your call to schedule.

We do offer TELEHEALTH as a convenient alternative for in-person visits. Continue with your care in a secure online visit with your therapist. No fees will be assessed for appointments converted to Telehealth.

1st late cancel/No Show per month	*Fee waived*
2nd late cancel/No Show	$25
3rd late cancel/No Show	$50
4th late cancel/No Show	$65

Exceptions may be made for inclimate weather based upon the school districts surrounding each of our offices. In addition, we have a set of guidelines to allow for cancellations related to COVID-19

I agree to abide by the above policy and to **pay the above fee PRIOR to my next appointment** if I am in violation. **I understand these charges will NOT be covered by my insurance company.**

X _____

Printed Name **Signature** **Date**

Therapist Reviewed (Initial): _____

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Financial Policies

Onondaga Physical Therapy is committed to providing unmatched one on one care while offering an easy and seamless billing process that eliminates waste and inefficiencies. **Effective 7/1/2022**, we require all patients to provide a **Credit Card on File** (CCOF), similar to the process used at hotels when checking in. When arriving for your first visit, we will scan your credit card through our encrypted card reader for any **unpaid** copays or patient balances. You will however always have the ability to pay by any payment method at time of service. This policy applies to all patients regardless of coverage for care.

Frequently Asked Questions:

How does the CCOF process benefit patients?
It is far more convenient for you - you don't have to bring your form of payment with you each visit unless you prefer to pay by other means. It makes check-in and check-out time much shorter if you tell the staff to use your CCOF. You don't have to call the office, buy a stamp or worry about getting around to paying your bill. It takes the hassle out of the process. If you get a statement and want to use a different card, pay by check, or discuss a payment plan, you may still do so as long as you do so promptly. Statements request payment within 10 days of receipt, and CCOF will be charged after 20 days of non-payment.

I've never had to do this before at any other healthcare office. Why are you requiring it?
While this may not yet be the norm in Central New York, many medical practices across the country have implemented CCOF policies. With the changing healthcare environment, more responsibility of payment is being placed on the patient, placing greater burden on providers for collection activity. This new process dramatically cuts down on the administrative costs associated with billing.

What if there is a problem with my bill and I don't notice it until after the payment processes?
We hope that this doesn't happen. But, if you find a problem, call us and we'll investigate it. If we owe you money, we will refund it promptly to the same card, another ease and benefit of CCOF.

My insurance covers my bill in full - why do I need to do this?
We apply the same policy to all of our patients. By doing it this way, the temptation to play favoritism is eliminated and it removes us from the uncomfortable situation of having to decide who has to follow the policy and who doesn't. Insurance companies typically don't cover equipment costs and do not cover no-show and cancellation fees that may be incurred.

I'm nervous about my card being stored.
We do not store your sensitive credit card information in our office. The gateway that stores your card information is a secure clearinghouse that meets the industry standards set forth by the Payment Card Industry Data Security Standard (PCI-DSS) and is certified. Once your card is added into the gateway, your information is securely encrypted and our staff can only see the last 4 digits for reconciliation purposes.

Specific policies based on coverage types:

Patients with Insurance Coverage

- As a service to our patients, we will submit claims to your insurance carrier. In order to do so, you must provide us with accurate information and up to date ID cards.
- As a courtesy to our patients, we will inform you of your benefits for physical therapy services - including annual limits on the number of visits, co-payments/coinsurances, deductibles & any other relevant details. This quotation is not a guarantee of coverage as the carrier determines coverage after final review of the claim.
- We ask that patients understand that an Insurance Policy is an agreement between the patient and the Insurance Carrier. We will work to resolve any issues in coverage within reason, however ultimately you are financially responsible for any balance left unpaid by the insurance carrier.

- If your insurance policy includes a Co-payment, Coinsurance, or Deductible, this will be collected at the time of service. We accept Cash, Check, Visa or MasterCard or Venmo.
- *If you are unable to pay for services in full, we require a payment plan agreement be in place which includes the Credit Card on File.* One of our Billing Department Staff Members will be happy to discuss a payment plan option.

Self/Cash-Pay Patients

- If you do not have insurance coverage, payment is due at the time of service. For your convenience, we accept Cash, Check, Visa or MasterCard or Venmo.
- As a courtesy to our patients who do not wish to use insurance to pay for their care, we do offer an affordable self-pay rate.

Worker's Compensation

- Our practice does accept Workers Compensation for your physical therapy services.
- Please provide our staff with accurate requested information regarding your work-related injury *at the time of scheduling your first appointment. This includes:* Carrier's name/address/phone number, Employer at time of injury, Date of Injury. This information is necessary to ensure we are compliant with Medical Treatment Guidelines put in place by the NYS Workers Compensation Board, and that your treatment will be covered.
- At your first appointment we may also request: Copy of injury report (if one is available) and any reports of Independent Medical Exams (IME) or other documents.

Auto Accident/New York State No Fault

- Our Practice does accept No Fault coverage for auto-related injuries that have occurred in New York.
- Please provide our staff with accurate requested information regarding your auto-related injury *at the time of scheduling your first appointment.*
- We will submit claims to the carrier as a courtesy, however it is ultimately your responsibility to be sure the case is still open/accepting of claims throughout your treatment. Without this, you will be responsible for the bill. It is important to inform us of any scheduled Independent Medical Exams (IMEs).

Patient Balances and other fees that are your responsibility:

- Estimated cost shares (ex. Copay, Deductible and Coinsurance) are due at the time of service.
- No Show and Cancellations fees are patient responsibility.
- Patient statements are mailed out every 30 days if cost share remains. Estimates are only approximated averages and coordination of benefits between payers may result in mailed statements.
- Payment is due 10 days from the receipt of your statement. If payment is not received within 20 days, your Credit Card on File will be charged.
- If you dispute the statement's accuracy or need a payment plan, contact us promptly for payment plan arrangements to be made.
- There is a $20.00 returned check fee due from you for each check returned by your bank.
- Please feel free to contact our Billing Department at (315) 635-5000, or visit our website for a list of Billing Frequently Asked Questions at www.onondagapt.com/faq

I have read and agreed to abide by the Financial Policies above. I further authorize Onondaga Physical Therapy to store and charge my Credit Card on File for any outstanding balances.

X_____

Patient/Guardian Signature Date

_____

Printed Name