NORTHERN IOWA THERAPY ASSOCIATES
THERAPY REGISTRATION FORM

Date: ___________________ Dr. Order Rec'd: PT ST OT Location: Clinic or Home

Patient's Name: ____________________________________ Date of Birth: _______________ Sex: M F
Home Address: ____ City/State: __________ ZIP: _________
SSN: __________________ Home Ph: _______________ Cell Ph: ________________ Email: ________________
Marital Status: S M D W Appt Reminders: Text or Email
Billing Address (if different than home): ___________________________ City/State: __________ ZIP: __________

Employed: Y N Employer: ____________________________ Job Title: ________________________________
Employer Address: ___________________________ City/State _______________ Phone Number: ______________

Emergency Contact ___________________________________ Relationship to Patient: ______________________
Address: ____ Phone: ________________________

Primary Health Insurance:
Responsible Party: ______________________________________ Relationship to Patient: ____________________
Insurance Carrier: _______________________________________ Phone: __________________________________
Policy Holder's Name: ___________________________________ Relationship to Patient ____________________
Policy Holder's Date of Birth: __________________ Policy Holder's SS#: ________________________________
Policy Holder's Employer: ____
Policy #: ________________________________ Group #: ________________________ Co-Pay: _________________

Secondary or Other Health Insurance:
Insurance Carrier: _______________________________________ Phone: __________________________________
Policy Holder's Name: ___________________________________ Relationship to Patient: ____________________
Policy Holder's Date of Birth: __________________ Policy Holder's SS#: ________________________________
Policy Holder's Employer: ____
Policy #: ________________________________ Group #: ________________________ Co-Pay: _________________

Worker's Compensation/Motor Vehicle Insurance:
Insurance Carrier: _______________________ Adjuster Name: _____________________ Phone: ________________
Policy /Case/Claim#: _________________ Date of Accident: ________________ Place of Accident: _____________
Have you completed paperwork with your employer? Yes or No
Please answer the following questions:

Question		
Is patient receiving any Home Health services?	YES	NO
Is the illness/injury work related and covered by work comp?	YES	NO
Was patient involved in a car or other type of accident?	YES	NO
Is another party responsible?	YES	NO
Is patient undergoing kidney dialysis or kidney transplant?	YES	NO
Is patient a disabled Medicare Beneficiary under age 65?	YES	NO
Are expenses paid by a government program?	YES	NO
Is patient entitled to Black Lung Medical Benefits?	YES	NO
Is patient/spouse/guardian employed and covered by Employer's Group Health Plan (EGHP)?	YES	NO

Primary Physician: ____________________ Location: _____________________________ Phone: _____________
Referring Physician: ___________________ Location: _____________________________ Phone: _____________
Diagnosis: ____ Onset: ______________________________
Medical History: ____
____
Primary Concern: ____
How did you hear about our Clinic? ____

NORTHERN IOWA THERAPY Assoc.
Occupational, Physical, Speech Therapy

Conditions of Admission

THERAPISTS: FAX TO 319-352-4655 WITHIN 24 HOURS OF EVAL DATE

This Agency does not discriminate on the basis of race, color, national origin, disability or age.

RELEASE OF INFORMATION: This agency may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to this agency, patient, family member or employer of the patient for all or part of this agency's care, including but not limited to medical service companies, physicians, insurance companies, workman's compensation carriers, welfare funds, or the patient's employer. The patient understands and agrees to allow this agency to use their Patient Health Information for the above purposes. We want you to know how your Patient Health Information is going to be used and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE, that is available to you at the front desk or from our staff, before signing this consent.

TREATMENT CONSENT: The patient is under the control of his/her physician and consents to any treatment or procedures rendered the patient by this agency under the general and specific instructions of the physician. It is further understood that the agency is hereby relieved of any and all liability occurring from the performance of the physician's instructions. I request and authorize the staff to provide me with physical, occupational and/or speech therapy and to perform any procedures now ordered or such additional procedures as may be authorized by my physician.

AGREEMENT ACCEPTANCE: The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as the patients' general agent to execute the above and accept its terms.

METHOD OF PAYMENT:
1. Medicare- 80% of charge is covered after the annual deductible has been met. The remaining 20% of the charge may be covered by supplemental insurance, Medicaid or by the patient.
2. Private Insurance- exact coverage will vary by plan.
3. Medicaid- (Title XIX) covers in full for children and nursing home patients and with a co-pay for some adults who are eligible.
4. Patient- will be responsible for treatment cost not covered by Medicare, Insurance and/or other available coverage. The patient will be billed for missed treatment time unless canceled a minimum of 4-5 hours prior to the scheduled treatment session.

FINANCIAL ACCEPTANCE: I hereby accept all responsibility for treatment costs not covered or reimbursed by third-party payers unless covered by Medicaid.

ASSIGNMENT OF BENEFITS: I hereby authorize Medicare, Insurance, Medicaid and/or other responsible coverage to make direct payment to this agency for benefits due me, if any, for services described in the statement rendered, and as provided for in the above agreement. I authorize any holder of medical and other information about me to release to Medicare, Insurance, Medicaid and/or other responsible coverage any information needed to determine these benefits or benefits for related services.

I certify that I have received or been offered the checked forms below.

____X_____ Privacy and Patients Rights Policy
____X_____ Advanced Directives Information

X ________________________________ ________________ ______________________________
Signature of Patient or Responsible Party *Date* *Witness (Person Securing Request)*

____
Relationship to patient if applicable

NORTHERN IOWA THERAPY Assoc.
Occupational, Physical, Speech Therapy

NORTHERN IOWA THERAPY ASSOCIATES, LLC
Conditions of Admission

This Agency does not discriminate on the basis of race, color, national origin, disability, sexual orientation, religion or age.

RELEASE OF INFORMATION: This agency may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to this agency, patient, family member or employer of the patient for all or part of this agency's care, including but not limited to medical service companies, physicians, insurance companies, workman's compensation carriers, welfare funds, or the patient's employer. The patient understands and agrees to allow this agency to use their Patient Health Information for the above purposes. We want you to know how your Patient Health Information is going to be used and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA information, that is available to you at the front desk or from our staff, before signing this consent.

TREATMENT CONSENT: The patient is under the direction of his/her physician and consents to any treatment or procedures rendered the patient by this agency under the general and specific instructions of the physician. It is further understood that the agency is hereby relieved of any and all liability occurring from the performance of the physician's instructions. I request and authorize the staff to provide me with physical, occupational and/or speech therapy and to perform any procedures now ordered or such additional procedures as may be authorized by my physician. I agree to complete all ordered/scheduled appointments and home program recommendations to obtain maximum results from therapy.

AGREEMENT ACCEPTANCE: The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as the patients' general agent to execute the above and accept its terms.

FINANCIAL RESPONSIBILITY: I agree that I am financially responsible for all charges relating to services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree it is my responsibility to obtain prior approval required by my insurance and to take all other steps to qualify for insurance coverage. Balance of bill payment is due within 30 days of final payment by insurance company. I UNDERSTAND I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES.

CO-PAYMENTS: Co-payments are due and payable on the date of service. We accept cash, check or credit cards. A $25.00 charge will be applied for returned checks.

SELF PAY PAYMENTS: If I am a self-pay patient, full payment is due on or before the time of service.
CANCELLATION FEE: Please help us serve you and all of our patients better by keeping your scheduled appointments. I understand that I will be responsible for a $25.00 cancellation fee if I do not cancel at least 24 hours prior to my scheduled appointment, and that the agency reserves the right to discharge for no show appointments.

ASSIGNMENT OF BENEFITS: I hereby authorize Medicare, Insurance, Medicaid and/or other responsible coverage to make direct payment to this agency for benefits due me, if any, for services described in the statement rendered, and as provided for in the above agreement. I authorize any holder of medical and other information about me to release to Medicare, Insurance, Medicaid and/or other responsible coverage any information needed to determine these benefits or benefits for related services.

I certify that I have received or been offered the checked forms below.

____X_____ ***Privacy and Patients Rights Policy***: Describes patient rights for respectful treatment, confidentiality and informed consent for treatment.

____X_____ ***Advanced Directives Information:*** Describes your legal right to have an advanced directive to refuse medical care. Describes Advanced Directive forms for a Living Will and Durable Power of Attorney for healthcare.

x ______________________________ ______________ _____ ______________________________
Signature of Patient or Responsible Party *Date* *Witness (Person Securing Request)*

______________________________ ______________________________
Relationship to patient if applicable) *Printed Patient Name*

Revised 6/10/2015; 4/12/2016; 8/9/2016