



**PATIENT REGISTRATION**

**OPT #5**

oxfordphysicaltherapy.com

Patient Name \_\_\_\_\_  
First Middle Last

Permanent Address \_\_\_\_\_  
Street City State Zip

Temporary Address \_\_\_\_\_  
Street City State Zip

Phone \_\_\_\_\_  
Home Work Cell

Emergency Contact \_\_\_\_\_  
Name Phone Relationship

Email Address \_\_\_\_\_ Sex:  M  F

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status  S  M  Wid  Div  Sep

Patient's Employer \_\_\_\_\_  
Phone Number

Employer's Address \_\_\_\_\_  
Street City State Zip

Date of Injury / Onset \_\_\_\_\_  
Referring Physician Family Physician

**PRIMARY INSURANCE INFORMATION**

Policyholder Name \_\_\_\_\_ Relationship DOB SSN

Address \_\_\_\_\_  
(if different than above) Street City State Zip

Policyholder's Employer \_\_\_\_\_ Phone Primary Insurance Company

Employer Address \_\_\_\_\_  
Street City State Zip

**SECONDARY INSURANCE INFORMATION**

Policyholder Name \_\_\_\_\_ Relationship DOB SSN

Address \_\_\_\_\_  
(if different than above) Street City State Zip

Policyholder's Employer \_\_\_\_\_ Phone Secondary Insurance Company

Employer Address \_\_\_\_\_  
Street City State Zip

**WORKER'S COMPENSATION CLAIMS**

Claim Number Date of Injury Employer at time of accident Phone

I will provide my Worker's Compensation claim number to you as soon as it arrives at my home. If I fail to provide my number or if my claim is denied, I will be responsible for payment.

Injured Worker's Signature \_\_\_\_\_ Date \_\_\_\_\_

I give my consent for Oxford Physical Therapy to leave a voice mail on my home/cell answering devices

Yes, Patient/Authorized Representative Initial  No, Patient/Authorized Representative Initial

**PLEASE READ AND SIGN THE OPPOSITE SIDE OF THIS SHEET**

## FINANCIAL POLICY

Thank you for choosing Oxford Physical Therapy as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. This is a financial responsibility on your part that obligates you to ensure full payment of your bill. Prompt payment allows us to control cost. Therefore, all patients will be required to establish financial arrangement for payment of their account. All patients must complete our information and insurance form before they see the physical therapist. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Your insurance policy is a contract between you and your insurance company.

### **Regarding Your Insurance - Important!**

We require your co-payment at the time of treatment. If the co-payment is not paid at the time of service a \$15.00 late fee will be assessed. In the event your insurance changes to a plan where we are not participating providers, refer to the above paragraph. It is your responsibility to know your benefits. We are not a party to that contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, ect. Other than to supply factual information as necessary. If you receive payment from the insurance company for services rendered by Oxford Physical Therapy you must reimburse Oxford Physical Therapy in full at the time of receipt of such payment. If you have secondary insurance you must present it at your initial visit. We will not retroactively bill a secondary insurance if you fail to provide all of the necessary insurance information. The balance will then become yours and you will have the responsibility of submitting the claim to your secondary insurance company. The patient agrees that if he or she defaults on any balance owed Oxford Physical Therapy and it becomes necessary for Oxford Physical Therapy to engage the services of an attorney, collection agency or other lawful method of collection, the patient will pay the original balance owed and reimburse Oxford Physical Therapy for all costs incurred by it in the collection of said debt.

### **Regarding Insurance Billing**

As stated earlier, we will bill your insurance company for you. However, you are ultimately responsible for payment of your bill. All claims are due and payable within 45 days of receipt of the insurance claim form. We will bill your insurance carrier no fewer than two times to ensure payment of your benefit for services rendered by Oxford Physical Therapy. However, in the event that repeated billing of your insurance carrier does not satisfy your balance for services rendered, we will have no choice but to look to you for full settlement of your account. **YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.** If paying by check you understand and authorize all dishonored checks plus a processing fee with applicable taxes to be charged to your account.

### **Missed Appointments and Late Charges**

Our policy is to charge \$40.00 for missed appointments, unless you cancel the appointment at least 24 hours in advance. This charge will be billed to you directly, not through your insurance company. A \$15.00 per month late fee is assessed on all unpaid balances.

**Minors** - The adult accompanying a minor is responsible for payment.

**Auto Insurance** - We will submit claims to your MedPay with your auto insurance. If you do not have MedPay, we will submit claims to your health insurance. In the event, you have obtained an attorney, we will require a letter of protection assuring Oxford Physical Therapy's financial interests will be protected in the event that the personal injury protection benefits become exhausted.

***I have read the above Financial Policy and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered by Oxford Physical Therapy.***

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Patient's Signature or Authorized Representative

Date

### **Consent to Treat and Authorization to Release Information**

I hereby authorize Oxford Physical Therapy, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and physical therapist in the treatment of my condition. I further authorize Oxford Physical Therapy to furnish and/or disclose my personally identifiable health information to the appropriate agencies for the purpose of billing.

I have had the opportunity to review Oxford Physical Therapy's Privacy Notice prior to signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my protected health information for treatment, payment and healthcare operations, but Oxford Physical Therapy is not required to agree to such a request, but if Oxford Physical Therapy does agree to my request, the restrictions will be binding.

I am allowing a photocopy of my signature to be used for insurance purposes. I also authorize my insurance company to pay directly to Oxford Physical Therapy the amount due me in my pending claim for insurance.

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Patient's Signature or Authorized Representative

Date