MONTGOMERY THERAPY
LLC

Patient Registration Form

Name: _____ **DOB:** _____/_____/_____ **SS#:** _____

Sex: M / F Marital Status: Single Married Divorced Widowed Other

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone # 1: _____ **Phone #2 :**_____

Emergency Contact: _____ **Phone #:**_____ **Relation:** _____

Referring Doctor: _____ **Body Part / Diagnosis:** _____

Date of Injury/Onset of Symptoms: ____/____/_____ **Surgery:** ____/_____/_____

Primary Insurance: **Insurance Company:** _____

Group #: _____ **ID#/Claim#:** _____

Answer if Policy Holder is different from Patient:

Name of Policy Holder: _____ **Sex: M or F**

Date of Birth: _____/_____/_____ **SS#:** _____ **Relation to Patient:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Worker's Comp: **Adjuster/Caseworker's Name:** _____ **Phone #:** _____

Auto Insurance: **Adjuster/Caseworker's Name:** _____ **Phone #:** _____

Have you submitted a PIP application to the Auto Insurance Company handling your case? Yes / No

If you answered no we will need a copy of this application to begin treatment.

Secondary Insurance: **Insurance Company:** _____

Group #: _____ **ID#/Claim#:** _____

Answer if Policy Holder is different from Patient:

Name of Policy Holder: _____ **Sex: M or F**

Date of Birth: _____/_____/_____ **SS#:** _____ **Relation to Patient:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

MONTGOMERY THERAPY LLC

Patient Medical History Form

Is this injury? □Work Related □ Auto Accident □ Other **Date of Injury**:_____

Chief Complaint:_____ **Condition:** □ New □ Acute □ Chronic

List any/all medications you are currently taking: _____

_____

Are you allergic to any medications? _____

List any surgeries:_____

Have you had any Diagnostic or Rehabilitative Services for this injury within this calendar year? Yes No:
If yes please explain: □ MRI □ Xrays **Other**:_____

_____

Do you now, or have you ever had, any of the following?

Yes No High Blood Pressure	**Yes No** Fibromyalgia	**Yes No** Pneumonia
Yes No Osteoporosis	**Yes No** TMJ Dysfunction	**Yes No** Nervous Disorder
Yes No Seizures	**Yes No** Diabetes	**Yes No** Pacemaker
Yes No Kidney Problems	**Yes No** OB/GYN Dysfunction	**Yes No** Pregnancy
Yes No Metal Implants	**Yes No** Osteoarthritis	**Yes No** Rheumatoid/Arthritis
Yes No Migraines/Headaches	**Yes No** Numbness/Tingling	**Yes No** Cancer
Yes No Lung Disease	**Yes No** Stroke	**Yes No** Bone Disease
Yes No Circulatory Disease	**Yes No** Angina/Heart Attacks	**Yes No** Hernia
Yes No Dizziness	**Yes No** Recent Weight Loss	**Yes No** Bowel Problems
Yes No HIV/AIDS	**Yes No** Previous Surgeries	**Yes No** Immunological Deficiencies

Yes No Problem with Both Arms, Or both legs at same time **Yes No** Urinary Incontinence/Bladder Problems

Yes No Allergies. *If yes, please explain*: _____ **Yes No** Fractures. *If yes, please explain*: _____

_____ _____

_____ _____

_____ _____

Sports _____ **Recreational Activities** _____

_____ _____

Other Medical Conditions: _____

_____

_____

Are you aware of your Diagnosis? YES ___ NO ___ **Are you aware of your Prognosis?** YES ____ NO ____

Patient's Name: _____ **Signature:** _____ **Date:** _____

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FINANCIAL POLICY

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, Discover, and Visa. **There will be a $25 fee for any checks that are returned to us unpaid.**

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.

2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.

3. In cases where a check is received personally from any insurance company for services rendered at Montgomery Therapy, LLC you agree to turn over all checks and payments to us.

4. With the exception of serious emergencies, it is expected that you keep all scheduled appointments. If you need to reschedule an existing appointment we require 24 hour notice. In such cases please call our office and arrange for a make up appointment for that same week. This will allow you and your therapist to again adhere to the agreed upon Plan Of Care. **In an instance of cancellation, without 24 hour notice and/or a no-show you will be charged a $50.00 fee.** Please understand that these actions directly affect other patients as well. The quality of work that we do and the reputation of Montgomery Therapy is evident in the popularity of our clinicians. An instance of repeated non-compliance with your scheduled visits also reserves our right to discontinue care. If such action is required, we will inform your physician that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. Your adherence to the recommended number of treatments is a vital component of your progress with our services and for you to see *optimal results.*

5. **Medicare patients** are responsible for their 20% co-insurance if they do not have secondary insurance or we do not participate with their plan. The 20% payment is due at the time of visit. Payment arrangements must be made prior to the first visit if needed.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. If any bills are turned over to a collection agency due to lack of payment, you will be held responsible for any and all collection and or attorney costs, including but not limited to, court costs and suit fees. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree.

SIGNATURE: _____ DATE: _____

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HIPAA AUTHORIZATION FORM

I, _____, give permission to Montgomery Therapy, LLC to:

_ use the following protected health information, and/or

_ disclose the following protected health information to: (please list the name and/or entities below)

_____

_____

_____

_____

_____

Information to be disclosed (check all that apply):

_ Medical Records
_ Treatment Records
_ Diagnostic Records
_ Other: _____

_____

_____

This protected health information is being used or disclosed for the following purposes:

_____

_____

_____

This authorization expires three (3) years from the date signed. (see below).

If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

You may inspect or copy the protected health information to be used or disclosed under this authorization. For protected health information created as part of a clinical trial, your right to access is suspended until the clinical trial is completed.

Finally, you may revoke this authorization in writing at any time by sending written notification Caitlin Ryan at 15245 Shady Grove Road, North Lobby-Suite C-100, Rockville, MD 20850. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

_____
Signature of Participant or Personal Representative

_____
Date

_____
Printed Name of Participant or Personal Representative

_____
Description of Personal Representative's Authority

I received a copy and/or reviewed the Privacy Practices and Patient Rights and Responsibilities Sheet

_____ _____
Patient Initials Date