Dear patient,

We welcome you to our Physical Therapy facility! Please provide the receptionist the following patient information at the time of your office appointment:

1. Your insurance card(s) and driver's license or photo ID.

2. The completed Registration packet.

3. Referral from the Doctor.

4. The Patient's Financial Responsibility page is to be printed and brought with you to the evaluation appointment and our staff will give you the quote of your benefits/patient's financial responsibility as informed by the health insurance(s).

    - Please note: if your insurance requires prior authorization for either the evaluation date or any follow up visits, we would inform you prior to the first visit/evaluation date.

    - Some insurance companies may require us to contact your primary physician and verify that an authorization has been given to receive Physical Therapy.

    - The authorization process can take between 48 hours to 14 business days, depending on the insurance. We will contact you when we receive authorization, and appreciate your patience and understanding as this process could take some time, depending on your insurance.

    - If you have not received a phone call from us to schedule your appointment by 4-5 business days, please contact our office for any updates.

    - On the day of your first appointment, please come to our office 15 minutes prior to your scheduled time, with all forms completed.

** Quite often our schedule may run a little behind, as it is the nature of a specialty practice to spend quality time with our patients. If you have any questions feel free to talk to any of our receptionists.

Thank you!
ALLIN Physical Therapy, LLC
10395 Narcoossee Rd. Ste. E Orlando, FL. 32832
P: 407.730.3244 | www.allintherapy.com

ALL IN PHYSICAL THERAPY, LLC – REGISTRATION FORM

PATIENT INFORMATION			
Patient's Name First:	M.I.:	Last:	
Address:	City:	State:	Zip:
Home Phone:	Cell Phone:	Email:	
Preferred Method of Appt. Reminders: ☐ Home Phone ☐ Cell Phone ☐ Text ☐ Email ☐ Check here For No Appt. Reminder			
Date of Birth:	Gender:	SSN:	
Date of Injury:	Place (State) of Injury:		
Emergency Contact:			
Relationship:	Phone:		

PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCE CARD		
Primary Insurance Company:		ID#:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Minor ☐ Other		
Employer:	Work Phone:	
Secondary Insurance Company (If Applicable)		ID#:
Name of Subscriber:	Date of Birth:	Group #:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Minor ☐ Other		
Employer:	Work Phone:	

GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)				
Name First:	M.I.:	Last:		
Address:		City:	State:	Zip:
Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Other		Date of Birth:		SSN:
Employer:		Work Phone:		

CONSENT FOR TREATMENT

Consent for Treatment: I hereby authorize ALL IN Physical Therapy, LLC to furnish rehabilitation therapy/treatment by a licensed healthcare practitioner as indicated by my referring physician. I authorize ALL IN Physical Therapy, LLC to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, social workers, insurance carriers or attorneys.

I authorize ALL IN Physical Therapy, LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I further understand no guarantees have been made to me as to the outcome of treatment.

Consent for Treatment of a Minor: As parent and/or legal guardian, I authorize and give my consent for ALL IN Physical Therapy, LLC, to treat (minor's name) _____ while I am not present.

Patient / Guardian / Responsible Party Signature **Date:**

ALL IN PHYSICAL THERAPY, LLC – OFFICE POLICY AND FINANCIAL RESPONSIBILITY

PATIENT INFORMATION CONSENT

I have read and fully understand ALL IN Physical Therapy, LLC's Notice of Information Practices. I understand that ALL IN PT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations by notifying the practice. I also understand that ALL IN PT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in ALL IN PT's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials _____

FINANCIAL RESPONSIBILITY

As a courtesy to you, ALL IN Physical Therapy, LLC will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. ALL IN PT is not responsible for issues between the patient and insurance carrier, nor can ALL IN PT intervene or negotiate for either party on disputed claims. Please advise us immediately if you change insurance coverage while undergoing treatment. Physical therapy equipment and/or supplies are typically not reimbursable by the insurance carrier. As such, ALL IN PT requires payment by the patient for any equipment/supply at the time the order is placed. ALL IN PT will provide a receipt as documentation of the purchase so you may pursue reimbursement personally. ALL IN PT accepts cash, personal checks, and credit cards (Visa, Mastercard, Discover, and American Express) as payment options.

Initials _____

Attending Scheduled Therapy Sessions is One Aspect of Your Recovery That You Control

CANCELATION, NO SHOW, AND DISCHARGE POLICIES

I acknowledge that I may incur a fee related to my attendance under the following guidelines.

- Cancellation Without 1-2 Hour Prior Notice: $10
- No Show: $20

I also acknowledge that I will forfeit any future scheduled time(s) if I have 2 no-shows without a reasonable cause. If I fail to schedule and attend follow-up appointments for a length of 30 days, I may be discharged from therapy. A new referral and evaluation will be required to proceed with additional therapy.

Initials _____

CONSENT TO CONFIDENTIAL MEDICAL INFORMATION

I hereby authorize ALL IN Physical Therapy, LLC to share any and all of my medical I billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

PATIENT AUTHORIZATION

- By my initials and signature, I understand these policies and my financial obligations for services rendered.
- I hereby assign payment of benefits by my insurance company to ALL IN Physical Therapy, LLC, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.
- I hereby agree to pay any office visit/co-payment charges at time of visit.
- I hereby agree to promptly pay my personal account balance including co-insurance or unmet deductible upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be required to effectively collect the debt.

Patient Signature: _____ **Date:** _____

Parent / Guardian / Guarantor: _____ **Date:** _____

ALL IN PHYSICAL THERAPY, LLC – FINANCIAL POLICY

PATIENT:	PRIMARY INSURANCE:

We have verified your insurance coverage and benefits as of _____.

This information is being provided to you exactly as it was told to us. Please INITIAL Highlighted Benefits Related to Your Policy.

☐ I have been informed regarding my copayment with my primary insurance.

☐ I have been informed regarding my coinsurance% amount that I will be responsible with my primary insurance and this will be calculated based on the insurance's allowable fees I charges my therapist will bill.

☐ I was informed in regards to my deductible with my primary insurance.

☐ There is an open or pending AUTO I INJURY claim. Claim number: _____

All financial responsibility of the patient is required at the time of service. We accept Cash, Personal Checks and Credit Cards (Master Card, Visa, Amex, Discover).

- **For patients with secondary or tertiary Insurance plans - Please inform us of this. We will provide you our secondary insurance plan policy.**
- **For orthotics evaluations and fittings-Please read the orthotic facility's policy.**
- **Please notify if you're receiving Home Health services or had received recently.**

Please be aware that your benefits and/or coverage quoted to us is simply an estimate and info may be subject to errors.

We strongly recommend that you contact your insurance directly if you have any questions or concerns regarding your physical therapy benefits.

If there are concerns regarding your financial responsibility for this service, please ask the front desk staff. You have the right to cancel today's appointment and not be treated today if you have concerns regarding your financial responsibility and you may choose to reschedule after you have your questions and concerns all answered. The cancelation of today's appointment is subject to a cancelation fee of $25.00.

Should you wish to discuss further any other questions you may email jgajo@allintherapy.com, Attn. Billing dept.

CONSENT: I understand these benefits as explained to me.	
Patient Signature:	**Date:**
ALL IN PT EMPLOYEE INITIALS:	**Date:**

ALL IN PHYSICAL THERAPY, LLC – MEDICAL HISTORY

Current Health Issues (What brings you to Physical Therapy?

Surgical History **Date**

Current Medications **Dosage**

Please check all that apply:

- ☐ **High Blood Pressure**
- ☐ **Diabetes**
- ☐ **Heart attack**
- ☐ **Pacemaker/metal implants**
- ☐ **Cancer**
- ☐ **Stroke/TIA**
- ☐ **COPD/breathing difficulties**
- ☐ **Fibromyalgia**
- ☐ **Medical Implants**
- ☐ **Vertigo**
- ☐ **MS**
- ☐ **Unexplained weight loss**
- ☐ **Night sweats**
- ☐ **Seizures**
- ☐ **Smoke/drink: yes/no. If yes, __/day.**
- ☐ **Arthritis**
- ☐ **Osteoporosis**
- ☐ **Frequent headaches**
- ☐ **Peripheral Neuropathy**
- ☐ **Other:**

ALL IN PHYSICAL THERAPY, LLC – NOTICE OF PRIVACY PRACTICES 1/2

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Your medical information is the information gathered by your therapists or other caregivers during the time you are being treated by ALL IN Physical Therapy, LLC professionals. It is private and no one without a legitimate need to know may have access to it. ALL IN Physical Therapy, LLC is required by law to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices.

ALL IN Physical Therapy, LLC will not use or disclose your health information except as described in this notice. This notice applies to all of the medical records generated during your participation in ALL IN Physical Therapy, LLC programs and services.

EXAMPLES OF THE DISCI.OSURE FOR TREATMENT, PAYMENT AMD HEALTH OPERATIONS

The following categories describe the ways that ALL IN Physical Therapy, LLC may use and disclose your health information:

Appointment Reminders: ALL IN Physical Therapy, LLC may use and disclose medical information to contact you at the contact number you provided to us or contact number given to us by your insurance company/physician, as a reminder that you have an appointment for treatment at ALL IN Physical Therapy, LLC. Upon your acknowledgement of this form, you accept a voice mail or any message left to you by our staff in attempt to leave you an appointment reminder.

Treatment: ALL IN Physical Therapy, LLC will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other health care providers who have a legitimate need for such information in the care and continued treatment of the patient.

Treatment Alternatives: ALL IN Physical Therapy, LLC may use and disclose your medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Payment: ALL IN Physical Therapy, LLC may release medical information about you for the purpose of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, the procedures and supplies used.

Routine Healthcare operations: ALL IN Physical Therapy, LLC may use und disclose your medical information during healthcare operations, including quality assurance, utilization review, internal auditing, accreditation, certification, licensing, or credentialing activities of the clinic, medical research and educational purpose. During our routine operations in our facility you may unintentionally hear other patient's name, but it is ALL IN Physical Therapy, LLC's policy and per HIPPA compliance to not divulge any other private medical information with you.

Business Associates: ALL IN Physical Therapy, LLC may use and disclose certain medical information about you to business associates. A business associate is an individual or entity under contract with ALL IN Physical Therapy, LLC to perform or assist ALL IN Physical Therapy, LLC in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a copy service used by the clinic to copy medical records, consultants, independent contractors, accountants, lawyers, medical transcriptionists and third-party billing companies. ALL IN Physical Therapy, LLC requires the business associate to protect the confidentiality of your medical information.

Regulatory Agencies: ALL IN Physical Therapy, LLC may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, billing practices may be audited by the State Auditor, and records are subject to review by the Secretary of Health and the Human Services.

ALL IN PHYSICAL THERAPY, LLC – NOTICE OF PRIVACY PRACTICES 2/2

Workers' Compensation: ALL IN Physical Therapy, LLC may release medical information about you for workers' compensation or similar programs that provide benefits for work related injuries or illnesses.

Military Veterans: ALL IN Physical Therapy, LLC may disclose your medical information as required by military command authorities if you are a member of the armed forces.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement officer. ALL IN Physical Therapy, LLC may release your medical record information to the correctional institution or law enforcement official.

Required by Law: ALL IN Physical Therapy, LLC will disclose medical information about you when required to do so by law.

Other Uses: Any other uses and disclosures will be made only with your written authorization.

PATIENT INFORMATION RIGHTS

Although all records concerning your treatment obtained at ALL IN Physical Therapy, LLC are the property of ALL IN Physical Therapy, LLC you have the following rights concerning your medical information:

Right to Confidential Communications: You have the right to receive communications of medical information by alternative means or at alternative locations. For example, you may request that ALL IN Physical Therapy, LLC contact you only at work or by mail.

Right to inspect and copy: You have the right to inspect and copy your medical information, after signing a release of Medical Information Agreement form.

Right to Amend: You have the right to amend your medical information.

Right to an Accounting: You have the right to obtain an accounting of the disclosures or your medical information.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. ALL IN Physical Therapy, LLC is not required to honor your request.

Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must he submitted IN WRITING, to ALL IN Physical Therapy, LLC. Forms to help you make your request are available at the Clinic.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our HlPAA Privacy officer, at (419) 221-3004. If you believe your privacy rights have been violated, you may file a complaint with ALL IN Physical Therapy, LLC or with the Secretary of the Department of' Health and Human Services. To file a complaint with ALL IN Physical Therapy, LLC, please contact the Front Desk located near the front entrance at the Clinic. All complaints must be submitted in writing. Forms are available in the lobby of the Clinic. There will be no retaliation for filing the complaint.

CHANGES TO THIS NOTICE

ALL IN Physical Therapy, LLC will abide by the terms of the notice currently in effect. ALL IN Physical Therapy, LLC reserves the right to changes the terms of its notice and to make the new notice provisions effective for all protected health information it maintains.