im | HEALTH

372 West Lancaster Ave
Wayne, PA 19087

Patient Registration

Full Name: _____ **DOB:** _____

Social Security #: _____ **Gender (circle one):** Male Female Prefer Not to Specify

Address: _____
Street City State Zip

Preferred Phone Number: _____ Home/Cell/Work

I allow IM | Health to text me health information and appointment reminders ☐ Yes ☐ No

I allow IM | Health to leave voice messages with health information and appointment reminders ☐ Yes ☐ No

Email Address: _____ I would like to be web-enabled ☐ Yes ☐ No
(Web enabling allows access to your Patient Portal)

Primary Care Physician Name/Phone: _____

Primary Care Physician Address: _____

Referring Physician Name/Phone: _____

Referring Physician Address: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Contact Phone Number: _____

****ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES****

I,_____, DOB:_____, acknowledge that I have been notified of this practice's privacy policy that includes medical and prescription history, and a written copy of this policy has been made available to me.

_____

Patient or Parent/Guardian Signature Date

(ELECTIVE) CONSENT TO RELEASE MEDICAL INFORMATION

I, hereby authorize the disclosure of my protected health information (including but not limited to results, prescriptions, and appointment) to the person(s) listed below.

Name: _____ Relationship_____

Name: _____ Relationship_____

Patient Consent for Treatment and for Use and Disclosure of Protected Health Information

I authorize medical treatment as deemed necessary and appropriate by the medical providers of ***IM / Health Physical Medicine*** and their employees participating in my care.

With my consent, ***IM / Health Physical Medicine*** may use and disclose Protected Health Information (PHI**)** about me to carry out treatment, payment, and healthcare operations. Please refer to the ***IM / Health Physical Medicine*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

With my consent, ***IM / Health Physical Medicine*** may call my home or other designated location and leave a message on voice mail in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, ***IM Health Physical Medicine*** may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations such as long as they are marked

With my consent, I authorize ***IM / Health Physical Medicine*** to release medical information regarding the care and treatment I have received from this office to the physicians I have listed on the reverse side of this form.

I have the right to request that ***IM / Health Physical Medicine*** restricts how it uses or discloses my **PHI** to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I authorize payment of insurance benefits directly to ***IM / Health Physical Medicine.*** I understand that I am fully responsible for any medical or surgical charge incurred in the course of my treatment, co-pay, deductible, all other charges determined to be patient responsibility or other type of unpaid service in excess of any hospitalization or health insurance that might be applicable.

I hereby authorize ***IM / Health Physical Medicine*** to release pertinent information to my health insurance companies required in the course of my examination or treatment.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent***, IM / Health Physical Medicine*** has the right to decline to provide treatment to me.

By signing this form, I am consenting ***IM / Health Physical Medicine's*** use and disclosure of my personal health information to carry out treatment, payment and healthcare operations.

Printed Name of Patient: _____Date:_____

Patient OR Guardian Signature: _____

Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing **IM | Health** for your medical needs. We are committed to providing you the highest quality healthcare, but we are not a collection agency.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care.

Please select ONE below:

☐ You agree to the **self-pay rate (initial PT evaluation - $135.00; follow-up PT visit - $95.00) for services rendered, at time of service.**

* ***IM | Health Physical Medicine*** *department is currently* ***NOT*** *in-network with any Aetna or Cigna health insurance plans. If you chose to proceed in scheduling Physical Therapy with* ***IM | Health****, please check off the above option.*

☐ You elect to use available medical insurance for visit coverage.

- We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.
- Copayments are due at the time of service.
- Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
    - You will NOT receive a bill. Your credit card on file will be charged, and a receipt published to your patient portal.

WE ARE NOT A COLLECTION SERVICE.
You will be charged for any balance your insurance contract designates as your responsibility.

*Please note when choosing **either** of the above options; **A VALID CREDIT CARD ON FILE WILL BE REQUIRED PRIOR TO SERVICE**

By my signature below, I hereby authorize assignment of financial benefits directly to **IM | Health** and any associated entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. **I also accept the fees charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, if such be necessary.**

Patient Name **Date of Birth**

Patient or Parent/Guardian Signature **Date**