REGISTRATION FORM

Last Name: ________________________ Middle Initial: ________ First Name: ________________________

Date of Birth: ______________________ Social Security Number: ________________________________

Address: ____

City: _____________________________________State: ______________Zip: _______________________

Home Phone: (___)_________________ Cell: (____)__________________ Work:(____)________________

Please circle the phone number you would like to use as your primary contact number.

Email address:____

Referring Physician: ______________________________ Primary Care Physician: ____________________

Employer: _______________________________________Date of Injury: ____________________________

Description of Injury: ____

____

Emergency Contact: _______________________ Relationship: _______________ Phone: _____________

Who Is Responsible for Medical Expenses?

Parent____Spouse____ Self____
Name:____________________________________
Address: __________________________________
Social Security Number:_____________________
Auto Ins. Company: _________________________
Work Comp Ins. Company:___________________

Work Accident____ Auto Accident ____
Attorney: ___________________________
Attorney's Number: ___________________
Copy of Police Report Yes No
Ins. Phone: __________________________
Claim Number:________________________

Primary Insurance Company: ____
Name of Subscriber: _______________________DOB: ______________________SSN: _______________

Secondary Insurance Company: ____
Name of Subscriber: _______________________DOB: ______________________SSN: _______________

Who referred you to Joyner Therapy? ____Doctor ____Family/Friend ____Other
Name of Doctor __________________ Name of Family/Friend______________

Insurance Authorization and Assignment

I hereby authorize treatment of the patient named above and agree to pay all fees and charges for services rendered. I authorized Joyner Therapy Services to submit billing and furnish information to insurance carriers concerning the illness and treatment of the patient named above. I hereby assign all payments from insurance carriers to be paid directly to Joyner Therapy Services for all medical services rendered.

Name (Print)____ Date _________

Patient Signature___________________________________

Responsible Party Signature_____________________________ Relationship_________________

Marion
2907 Williamson Co Pkwy
p. 618-998-9894
f. 618-998-9993

Harrisburg
924 S Commercial St
p. 618-252-7171
f. 618-252-7272

Carmi
108 April Ave
p. 618-382-2771
f. 618-382-2772

Joyner Therapy Services
PHYSICAL • OCCUPATIONAL • SPEECH
MASSAGE • HOME HEALTH • LONG TERM CARE

Health History

If yes, please describe:

Depression/Anxiety	Yes	No	
Pacemaker	Yes	No	
Defibrillator	Yes	No	
High Blood Pressure	Yes	No	
Heart Disease	Yes	No	
Cancer	Yes	No	
Diabetes	Yes	No	
Shingles	Yes	No	If yes when/where?
Tuberculosis	Yes	No	
Hep A, B, C	Yes	No	If yes which?
HIV	Yes	No	
Recent Surgery	Yes	No	
Joint Replacement	Yes	No	If yes, what Joint?
Arthritis	Yes	No	
Osteoporosis	Yes	No	
Serious Injuries	Yes	No	
Neurological	Yes	No	
Seizure Activity	Yes	No	
Bowel/Bladder Issues	Yes	No	
Pregnant	Yes	No	
Tobacco Use	Yes	No	
Recent Falls (within the last 12 months)	Yes	No	If yes how many falls?

Have you had any Physical Therapy, Occupational Therapy or Speech Therapy in the past? If so what for and when did you have the therapy? ____

Height ______________________________ Weight ______________________________

List of Medication

(If you have a list of medication, give it to the receptionist to make a copy of it)

Medication	Dose	Frequency

Transfer of Medical Information

You may release information regarding my appointments, and discuss any medical and/or therapy details with the following individuals:

Name	Relationship	Telephone Number

In the event Joyner Therapy Services needs to contact you regarding scheduling or changing your appointment times or to discuss a medical matter pertaining to your case, we will make every attempt to contact you directly. **In the event we are unable to reach you, please indicate your preferences below.**

☐ You may leave messages regarding appointments or medical information by the following methods:

- ☐ On my personal voicemail either at home or on my cell phone.
- ☐ With a family member in my home from the list above.
- ☐ On my work voicemail. Only a message stating to call Joyner Therapy.

☐ You may not leave messages of any kind pertaining to my medical care or appointments.

Patient Signature ____Date ______________________

Legal Guardian/Parent ____

Relationship to Patient ____

Medical Assignment of Benefits & Financial Policy

We at Joyner Therapy Services are pleased to be a part of your rehabilitation experience and thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

Insurance Billing

As a courtesy, we will gladly call your insurance company to identify what your benefit coverage is. However, please understand that **insurance companies will not guarantee medical benefits over the phone.** We can only use this information as an **estimated guideline.** Actual determination is made 4 to 8 weeks later when we receive written notification and/or payments on your claim. We **strongly** encourage you to contact your insurance company directly in order to understand your plan's coverage and limitations.

Your insurance company may also require a "Letter of Medical Necessity" written by your physician and/or pre-authorization directly from your physician for therapy services. This is your responsibility to obtain and non-compliance with this may result in services not being reimbursed by your insurance company.

If, at any time, we receive a denial on your account (private insurance, work-comp, personal injury, Medicare, etc.) the patient or legal guardian understands that they are 100% responsible for all charges incurred with Joyner Therapy Services and agrees to pay all amounts due, in full, within 30 days, unless a payment agreement has been arranged with our facility.

Payments

All co-pays, and estimated cash pay amounts are due at the time of service, unless other arrangements have been made with our facility. Cash pay patients will receive a discounted rate when payments are made in full. Actual determination of any amounts you owe for deductible or co-insurance will be determined after we receive written notification and/or payments on your claims.

Once we have received all payments of notification from your insurance company, we will present you with your final statement. Payment for any outstanding balance will be due within 30 days after the receipt of the statement. To make costs more affordable, we advise you to pay toward your deductible or co-insurance throughout the duration of your therapy. Payments can be made at the front desk. If we do not receive a payment within 90 days after receipt of the first notice of balance, we may be forced to pursue legal collection proceedings. Please do not hesitate to ask us any questions or request a copy of your account balance.

Returned Checks

There is a $25 fee charged by Joyner Therapy Services for any checks returned by the bank.

Missed Appointments

There is a $20 fee for any "no-call/no show" appointments that were previously scheduled. This fee will be billed to you on your next billing statement. Patients that have 3 consecutive "no-call/no-show" appointments will be discharged at the time and asked to obtain a new prescription from your physician to return to therapy. Joyner Therapy Services reserves the right to refuse resumption of care at any time.

We strongly advise that any cancelled appointment be re-scheduled from that **same week,** in order to remain in compliance with your already assigned plan of care. Please be advised that if you are a "work-comp" patient we must notify your physician and work-comp case manager of any and all missed appointments.

If it is necessary for the patient to be more than 10 minutes late to an appointment, our office must be notified. Failure to do so may result in cancellation of that session. We reserve the right to bill a no-show fee in the event your appointment is canceled due to late arrival.

It is preferred by Joyner Therapy Services that we are notified 24 hours in advance of any appointment that needs to be cancelled.

By signing this form, I the patient (or legal guardian of the patient), have read, understood, and agree that I am 100% responsible for all fees incurred at Joyner Therapy Services that are not covered by my insurance company. I agree to authorize Joyner Therapy Services to release my medical information to insurance companies, physicians, attorneys and to all other pertinent parties that may be involved in my claim or healthcare. I also agree to assign all payments of benefits to Joyner Therapy Services.

Patient Signature ____ Date________________

Legal Guardian/Parent ____

Relationship to Patient ____