KEMPTON & KEMPTON
PHYSICAL THERAPY

Patient Registration Forms

Patient Name: ______________________________ DOB: ______________

Street Address: ______________________________

City: ______________________ State: __________ Zipcode: ______________

SSN: ______________ Marital Status: __________ Email: ______________

Primary Phone Number: ______________________ Secondary: ______________

Emergency Contact: ______________________ Relationship: ______________

Phone Number: ______________________ Secondary: ______________

Doctor that referred you here today: ______________________________

Description of symptoms: ______________________________

____

Onset/Injury/Accident/Surgery Date: ______________________________

Description of Injury/Accident/Surgery: ______________________________

____

Related to Accident? __Yes ___No Nature of Accident __ Auto __ Work Related __ Other

Primary Insurance

Insurance: ______________ ID: ______________ Group: ______________

Policy Holder Name: ______________________________ DOB: ______________

Secondary Insurance

Insurance: ______________ ID: ______________ Group: ______________

Policy Holder Name: ______________________________ DOB: ______________

Personal Injury/Workmans Comp Company

Adjustor/Case Manager Name: ______________________ Claim #: ______________

Responsible party (if auto accident) ______________________________

KEMPTON & KEMPTON

PHYSICAL THERAPY

Medical History

Please put a checkmark next to all that apply

Arthritis ___________ Diabetes ______________ Leg/Lung Clots _____________

Asthma ____________ Heart Disease __________ Migraines __________________

Cancer ____________ Heart Failure __________ Osteoporosis ________________

CVA _____________ Hypertension __________ Syncope/Collapse ____________

Other important information: ____

____

Surgical History:

____

____

____

____

Current Medications:

____

____

____

____

Any Concerns or limitations we should know about regarding your care:

____

____

____

____

Kempton & Kempton Physical Therapy

8490 S. Power Rd Ste 115 Gilbert, AZ 85297 Phone: (480) 840-3564 Fax: (480) 840-3565

KEMPTON & KEMPTON

PHYSICAL THERAPY

Financial Policy and Patient Responsibility

Kempton and Kempton Physical Therapy is committed to providing our patients with the highest quality care.
We thank you for taking the time to read and understand our policy.

It is the patient's responsibility:

- To know their insurance policy. Patients should be aware of their benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, coinsurances and co-payments. If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and /or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.
- To pay their co-payment on the date of service (DOS). Coinsurance or deductible estimate is also due on the DOS. Underpaid coinsurance/deductible will be billed upon receipt of all Explanation of Benefits (EOB) from insurance. Refunds for any over payments will be processed at the end of the total treatment period. Late payment fee is applied on past de co-insurance bills.
- To pay any Medicare deductible and coinsurance amounts not covered by supplemental insurance.
- To promptly pay any patient responsibility indicated by their insurance carrier.
- To facilitate in claims payment processing by contacting their insurance carrier when claims have not been paid and by providing any requested and/or additional information to insurance as required.
- To provide correct insurance billing information at the time of office visit and to report changes to the insurance information when necessary.
- To agree on a late payment fee of 1.5% of balance due each month or a monthly minimum late payment fee of $5.00, whichever is greater, for every 30 days past due form statement date.
- To know a $25.00 fee be applied in the event of a returned check. In addition, there is a $25.00 charge for no show appointments, which were not cancelled 24 hours in advance.
- ***Non-Insured Patients***: Agree to be responsible for full payment at the time of service, unless prior arrangements have been made with our office. Discounts are given when paying in full on the day that services are rendered.

It is Kempton and Kempton Physical Therapy's responsibility:

- To provide quality medical care.
- To file insurance claims as a courtesy to the patient. A 90-day period will be extended for pending insurance payment, after which the patient may held responsible for the balance.
- We accept payment in cash, person check with proper identification, debit cards, Visa, Mastercard, Discover and American Express. Minimum card payment is $30.00 per transaction.

Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsibly for the balance on my account for any services rendered. I also authorize my insurance carrier to make payment directly to Kempton and Kempton Physical Therapy. I authorize the release of medical information to my insurance company or their agent necessary for filing health insurance claims on my behalf, as well as full report of my case history, examination, diagnosis, treatment notes and itemized billing statement to my attorney as required for account settlement.

Patient/Parent/Guardian or Responsible Party Signature — Date

Kempton & Kempton Physical Therapy

8490 S. Power Rd Ste 115 Gilbert, AZ 85297 Phone: (480) 840-3564 Fax: (480) 840-3565

KEMPTON & KEMPTON

PHYSICAL THERAPY

Acknowledgement of Review and/or Receipt of
Notice of Privacy Practices

Respect for our patients' privacy has always been highly valued at Kempton and Kempton Physical Therapy and Sports Rehabilitation, LLC. Not only is it what our patients expect, it is the right way to conduct healthcare business.

As required by law, we will protect the privacy of health information that may reveal your identity and if requested, provide you with a copy of our Notice of Privacy Practices, which describes the health information privacy practices of our facility, our staff and other affiliated health care providers when providing health care services to you. Our Notice is available in the front office. You will also be able to obtain your own copy by asking for one at the time of your next visit.

By signing now, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been notified of how health information about me may be used and disclosed by the facility, and how I may obtain access to and control this information. Finally, by signing below, I consent to the use and/or disclosure of my health information to treat me and arrange for medical care, to seek and receive payment for services rendered, and for the business operations of the facility and its staff.

____

Signature of Patient of Personal Representative

____

Print Name of Patient or Personal Representative

____

Relation to Patient (POA)

____

Date

Kempton & Kempton Physical Therapy

8490 S. Power Rd Ste 115 Gilbert, AZ 85297 Phone: (480) 840-3564 Fax: (480) 840-3565