CYPRESS
PHYSICAL THERAPY

Patient Registration Form

Personal Information

Name:		Name you prefer:
Home Address:		Apt #
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Injury/ Diagnosis:		Home Phone:
Date of Inury/Onset of symptoms:		Work Phone:
Date of Birth:	Age:	Cell Phone:
Email Address:		
Emergency Contact:		Emergency Contact Phone #:
How did you hear about us?:		

Referring Physician Name:		Phone #:
City, State:		
Primary Care Physician Name:		Phone #:
City, State:		
Employer Name:		Occupation:
Address:		City, State:
Social Security Number (For Insurance Benefit Verification):		

Primary Insurance Information

Is this an auto accident?:	Yes	No	Is this a worker's comp case?:	Yes No
If "Yes", list claim # and adjuster contact information:				
Health Insurance Company Name:				
Subscriber's Name:			Subscriber's Date of Birth:	
Relationship to the Subscriber:				
Subcriber's Address and Phone # if different from patient:				
Address:				
City, State		Zip		Phone#

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Consent of Care and Treatment

For and in consideration of the medical treatment, which I will receive while a patient at Cypress Physical Therapy, I either severally or collectively consent to treatment, voluntarily and knowingly, by me, if of age and competent, and by a parent or legal guardian if a minor or incompetent. I authorize the said members of Cypress Physical Therapy, severally or collectively, to carry out, or cause to be carried out such medical treatment as prescribed or ordered by my physician.

_____(please initial) I have read, understand, and agree to the above.

Authorization to Release Information and Assignment of Benefits

I hereby authorize Cypress Physical Therapy, or any holder of medical information about me, to release to the Healthcare Admisstration and it agents (Medicare, Insurance Companies, or Third Party Paryers) any information to determine those benefits or benefits payable for related services. I request that all authorized Medicare or Insurance payments of medical benefits be made to Cypress Physical Therapy, or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

_____(please initial) I have read, understand, and agree to the above.

Authorization to Release or Obtain Medical Information

I hereby authorize Cypress Physical Therapy, to obtain or release copies of my medical records, relative to the diagnosis, treatment, and prognosis of my illness, injury, or condition.
If there is anyone you would like to authorize the disclosure of your Personal Health Information, or PHI, you may specifically name the party below and indicate what your relationship to that party. If you are a student athlete, we MUST have all coaches, trainers, or administrative personnel that you would want to have access to the status of treatment.

1. Name:_____Relationship:_____
2. Name:_____Relationship:_____
3. Name:_____Relationship:_____
4. Name:_____Relationship:_____
5. Name:_____Relationship:_____

_____(please initial) I understand and agree that if no other party is listed here, Cypress Physical Therapy can not discuss PHI with anyone other than my referring provider or insurance company.

Privacy Notice

By my signature below, I acknowledge that I have received a copy of the "Notice of privacy Practices," and understand my rights as a patient regarding my personal health information.

If you would like a copy of the Notice of Privacy Practices, please speak to the front desk, or email info@cypresspt.net with any questions or concerns you may have.

_____(please initial) I have read, understand, and agree to the above.

Financial Policy

Thank you for choosing Cypress Physical Therapy as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. We need your assistance, and your understanding of our payment policy. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- We will file your insurance as a courtesy
- We will expect full payment of your co-pay at the time of visit, as well as deductible responsibility
- After your insurance has paid your claim or denied it, we will expect full payment on the balance of your account
- We accept cash, check, and credit or debit card

In an effort to provide quality treatment to our patients while meeting the financial needs of the business, Cypress Physical Therapy offers financial assistance on a case by case basis. If you would like more information on our Financial Hardship Policy, please do not hesitate to speak to the front desk.

_____(please initial) I have read, understand, and agree to the above.

Patient Printed Name:_____

Patient Signature:_____

Date: _____

Facility Representitive:_____

No call/no Show Policy

In an effort to provide quality treatment to patients with the necessary staff while meeting the financial needs of the business, Cypress Physical Therapy shall charge a "no show" fee per visit after the first three "no shows" for a patient if the appointment is not cancelled/rescheduled 24 hours before appointment time.

No Show Fee: $20

I authorize Cypress Physical Therapy to charge my credit card on file or add the fee to my patient file and bill me.

_____ _____

SIGNATURE DATE

_____

PRINTED NAME

_____

Card #

_____ _____ _____

Expiration Date Code Zip Code

Appointment Waitlist Preferences

Please fill out your appointment time/day preferences below: (What days and times are ideal for you and your schedule?)

- In our new medical record system, Prompt, we have the ability to send you communication via text/email to quickly schedule appointments that you prefer. If we have an opening that meets your desired time/day preferences, we will text/email you to let you know and give you a chance to book those visits with one-click before someone else does.

Sun Mon Tue Wed Thu Fri Sat

- ☐ Early Morning (Before 8am)
- ☐ Morning (8am - Noon)
- ☐ Afternoon (Noon - 5pm)
- ☐ Evening (After 5pm)

	Before 8am	8am - Noon	Noon - 5pm	After 5pm
Sun	☐	☐	☐	☐
Mon	☐	☐	☐	☐
Tue	☐	☐	☐	☐
Wed	☐	☐	☐	☐
Thu	☐	☐	☐	☐
Fri	☐	☐	☐	☐
Sat	☐	☐	☐	☐

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Authorization to Store and Charge Credit Card Information

- By providing your credit card information, you authorize Cypress Physical Therapy to securely store your credit card information for the purposes described in this agreement.
- You agree that Cypress Physical Therapy may charge your credit card on file for any balances owed on your account that remain unpaid for more than ninety (90) days from the original due date.
- Cypress Physical Therapy will provide you with written notice, via email or mail, at least 15 days prior to charging your card for delinquent balances, giving you an opportunity to pay by alternative means.
- The maximum charge applied to your card will not exceed the outstanding balance owed, including any applicable no show/ late cancellation fees.
- You may revoke your authorization for Cypress Physical Therapy to store and charge your credit card at any time by contacting Cypress Physical Therapy. However, you remain responsible for ensuring that your account is paid in full in accordance with Cypress Physical Therapy Financial Policy terms.
- Cypress Physical Therapy will securely store and process your credit card information in compliance with applicable laws and industry standards, including the Payment Card Industry Data Security Standard (PCI DSS).
- In the event of a billing error or unauthorized charge, please contact Cypress Physical Therapy immediately to resolve the issue.
- By providing your credit card information and signing this agreement, you acknowledge and agree to the terms outlined above.

Patient Name (Please Print):_____

Patient Signature:_____ Date: _____