Wind City Physical Therapy

Welcome to our practice!

On behalf of our staff, we welcome you to our office. We are pleased that you have selected us to care for your physical therapy needs. We want you to know that we are committed to providing you with the highest quality care in the most innovative, efficient, and enthusiastic manner possible. We pride ourselves on making your personal therapy plan a pleasant experience for you, while providing you with the best possible treatment.

Our emphasis focuses on and overall wellness to ensure that you have the best possible results. During your first visit, your therapist will do an evaluation and create a baseline of your status, so we can track your performance and an individualized treatment plan will be tailored especially for you. By completing your recommended plan, you will get optimal results.

Should you have any questions about our practice, services, or policies please do not hesitate to contact our office or visit our website at www.windcitypt.com. We look forward to your next visit and thank you again for the opportunity to assist you with your therapy needs.

Sincerely,
Wind City Physical Therapy

Wind City Physical Therapy
1541 Centennial Ct
Casper WY 82609

Wind City Physical Therapy
925 W Birch St
Glenrock WY 8637

Registration Form

PATIENT INFORMATION			
Patient's Name First :	Last:		
Address:	City:	State:	Zip:
Home Phone:	Cell:		
Email:			
Preferred Method of Appt Reminders: [ ] Home Phone [ ] Cell Phone [ ]			
SSN#			
Date of Birth:	Gender:		
Date of Injury:	Place (State) of Injury:		
Emergency Contact:	Phone:( )		
Relationship:			
Employer:	Phone:( )		
How did you hear about us?			
Referring Dr:	Phone:		
Primary Dr:	Phone		
Dentist:	Phone:		
PATIENT INSURANCE INFORMATION - PLEASE BRING YOUR INSURANCECARD			
Primary Insurance Company:			
Name of Subscriber:			
ID #	Group #		
Relationship to Subscriber: (Circle One)	Self / Spouse / Minor / Other		
Subscriber Date of Birth	Subscriber SSN #		
Secondary Insurance Company (If Applicable):			
Name of Subscriber:			
ID #	Group #		
Relationship to Subscriber: (Circle One)	Self / Spouse / Minor /Other		
Subscriber Date of Birth	Subscriber SSN #		
GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)			
Name Last:	First:	M.I.:	SSN:
Address:	City:	State:	Zip:
Relationship to Subscriber: (Circle One)	Self / Spouse / Minor / Other		

WORKERS COMPENSATION INFORMATION			
CLAIM NUMBER:			
Name of Employer:			
Address:	City:	State:	Zip:
Phone:	Fax:		
Case Manager:	Phone:		
Name of Adjustor:			
Phone: ( )	Fax: ( )		

Motor Vehicle Information			
CLAIM NUMBER:			
Name of Insurance:			
Address:	City:	State:	Zip:
Phone:	Fax:		
Name of Adjustor:			
Address:	City:	State:	Zip:
Phone:( )	Fax: ( )		
Attorney Information			
Firm Name:	Attorney Name:		
Address:	City:	State:	Zip:
Phone:	Fax:		

CONSENT FOR TREATMENT

Consent for Treatment: I understand I have the right to choose my physical therapy provider and have chosen Wind City Physical Therapy and Wellness Services. and I hereby authorize and give my consent for Wind City Physical Therapy to furnish physical therapy care and understand treatment deemed necessary or advisable in evaluating or treating my physical condition. I further understand no guarantees have been made to me as to the outcome of treatment.

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

Patient Name:_____

OFFICE POLICY AND FINANCIAL RESPONSIBILITY

Notice & Consent to Treat: Acknowledgement of Receipt

By signing this form, you acknowledge that you have been offered a copy for review of Wind City Physical Therapy Notice of Privacy Practices which is prominently displayed in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact our Privacy Officer at (307) 235-3910

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Initials

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS: I hereby authorize Wind City Physical Therapy, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize Wind City Physical Therapy to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me reminders of my appointments via text messaging. I am assigning my therapy benefits to Wind City Physical Therapy for the services in which I receive and authorize my insurance carrier to make payments to Wind City Physical Therapy on my behalf. Wind City Physical Therapy reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to Wind City Physical Therapy before they are released, regardless of requester. Wind City Physical Therapy is HIPAA compliant with regard to information sharing policies.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above.

I further understand and acknowledge that Wind City Physical Therapy may lease or license real estate, equipment or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

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Initials

FINANCIAL RESPONSIBILITY: As a courtesy to you, Wind City Physical Therapy will file your medical insurance claims. The contract between you as a patient and your insurance company is, however, personal to you. Wind City Physical Therapy is not responsible for issues between the patient and insurance carrier, nor can Wind City Physical Therapy 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, Wind City Physical Therapy requires payment by the patient for any equipment/supply at the time the order is placed. Wind City Physical Therapy will provide a receipt as documentation of the purchase, so you may pursue reimbursement personally. Wind City Physical Therapy accepts cash, check, Visa or Mastercard as payment options. I agree to pay any office visit/co-payment deductible charges at time of visit. I 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.

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Initials

LATE POLICY "15 MINUTES": Being late by more than 15 minutes may require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable.

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Initials

CHILDREN REQUIRING SUPERVISION ARE NOT ALLOWED TO ATTEND SESSIONS WITH YOU: If your child does not require supervision and is capable of waiting for you quietly in the waiting area, then you may bring them. If any disturbance is caused to other patients or staff members, you may be asked to terminate your session early and attend to your child. Children are NOT ALLOWED in the gym area while you or other patients are using the equipment.

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Initials

CONSENT FOR CONTACT:

I agree that Wind City Physical Therapy can contact me via text or email for appointment reminders. I may be contacted with medical and treatment information, including patient statements, via email.

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Initials

MEDICARE WAVIER STATEMENT (IF APPLICABLE): Anyone who misrepresents or falsifies essential information requested by this form may, upon conviction, be subject to fine and imprisonment under Federal Law. Medicare will only pay for services that it determines to be reasonable and necessary under section 1862 (a) (1) of the Medicare Law.

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Initials

CONSENT TO CONFIDENTIAL MEDICALINFORMATION

I hear by authorize Wind City Physical Therapy to share all my medical / billing information with the following people.

Full Name:_____ Relationship: _____

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

Date:_____ Patient Name:_____ DOB:_____

Patient Name ______________________

PATIENT PRESCRIPTION MEDICATION AND OVER THE COUNTER / SUPPLEMENT

Please list any ALLERGIES to Medications:			
Current Medications	**Dose (ex. mg ormcg)**	**How Taken? (mouth or injection)**	**How many times taken**

Wind City Physical Therapy
1541 Centennial Ct. Casper WY 82609
307-235-3910 Phone 307-266-2891 Fax

Authorization for Release of Medical Information

Name: _____ DOB_____
City: _____State: _____Zip: _____

PLEASE SEND *ONLY* THE MOST RECENT OF THE FOLLOWING

I authorize Wind City Physical Therapy to receive my medical records from the following physician or clinic:

				Fax #
Dr Santiago	EMG			307-234-9042
WY Medical Center	X-Ray	MRI	CT SCAN	307-233-8146
CHCCW (Community Health Center)	X-Ray	MRI	CT SCAN	307-233-6039
UW Family Practice	X-Ray	MRI	CT SCAN	307-234-7032
Western Medical	X-Ray	MRI	CT SCAN	307-233-0615
Outpatient Radiology	X-Ray	MRI	CT SCAN	307-577-0443
Other	X-Ray	MRI	CT SCAN	EMG

I understand this is Limited authorization and does not allow for release to additional parties.

Purpose for release

ASSIST IN WIND CITY PHYSICAL THERAPYTREATMENT:

_____ _____
Signature Date

_____ _____
Signature (legal Guardian) Date