REGISTRATION & CONSENT FORMS

TODAY'S DATE______________________

PATIENT NAME____ CELL PH #_______________________

PREFERRED NAME (if different)_____________________________ OTHER PH#_____________________

ADDRESS____ STE/APT_________________________

CITY____ ST________ ZIP______________________

SEX ____M ____F GENDER IDENTITY________________ PREFERRED PRONOUNS________________

BIRTHDATE_______/_______/____________ DOCTOR____

E-MAIL____

HOW DID YOU HEAR ABOUT US?____

IS THE PATIENT A MINOR? _____YES _____NO GUARANTOR'S NAME___________________________

GUARANTOR'S DOB______/_______/___________ RELATIONSHIP________________________________

ARE WE BILLING INSURANCE FOR YOUR TREATMENT? _____YES _____NO - If no, skip to page 2.

PRIMARY INSURANCE CO______________________________________PHONE#____________________

MEMBER ID#_______________________________________GROUP#_________________________________

SECONDARY INS CO____ PHONE#____________________

MEMBER ID#_____________________________________ GROUP#___________________________________

SUBSCRIBERS NAME____________________________________ SUBSCRIBERS DOB_________________

PERSONAL INFORMATION & INSURANCE

I certify that all of the information provided herein is complete and accurate to the best of my knowledge. I agree to notify Connect & Beyond Physical Therapy immediately of any changes to my personal information, including my insurance status.

RESCHEDULING & MISSED APPOINTMENT POLICY

Connect & Beyond Physical Therapy strives to provide each patient with the highest quality care while accommodating individual schedules. We reserve appointment blocks for each patient to minimize waiting times and ensure continuity of care. Your consistent attendance is paramount to your full recovery.

We understand that unexpected events can occur. In our effort to be both effective and fair to all our patients—and in consideration of our providers' time and resources—at least 48 business hours' advance notice is required when rescheduling or canceling an appointment. Since our office is closed on weekends, for a Monday appointment, 48 business hours would be counted from the preceding Thursday.

If you are unable to provide the required notice, a $100 missed appointment fee will be added to your monthly statement.

If you anticipate being late for an appointment, please notify us as soon as possible. While we will do our best to accommodate you, there may be occasions when rescheduling is necessary.

All cancellations and missed visits are documented in your medical record and reported to your physician and your insurance company/third-party payer. If you accumulate three canceled or missed appointments, your therapist may refer you back to your physician before scheduling any future appointments.

Thank you for your understanding and cooperation.

FINANCIAL AGREEMENT

I understand that it is my responsibility to know my insurance benefits and to pay for all physical therapy services, regardless of insurance or third-party coverage.

As a courtesy, Connect & Beyond Physical Therapy will process your insurance claims and send you a monthly statement. Payment may be made by cash, check, or credit card, and insurance co-payments are due at the time of service. I authorize the payment of my medical benefits to Connect & Beyond Physical Therapy. Any credit balance on my account will be refunded promptly.

For claims that are in litigation or dispute, prior arrangements must be made regarding payment on your account.

By signing here, I understand and agree to the above: ________________________________

PAYMENT CARD ON FILE

For your security and protection, Connect Physical Therapy stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Connect Physical Therapy to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Connect Physical Therapy of any updates or changes to the credit card on file associated with this agreement as soon as possible.

STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have been provided with Connect & Beyond Physical Therapy's Statement of Privacy Practices. This notice describes the types of uses and disclosures of my protected health information that may occur during my treatment, the payment of my bills, or the performance of health care operations by Connect & Beyond Physical Therapy, as well as my individual rights and our duties with respect to my protected health information.

Connect & Beyond Physical Therapy reserves the right to change the privacy practices described in its Statement of Privacy Practices. Any revised notice will be posted in our office, and you may request a copy by contacting us, downloading one from our website, or asking for one at your next appointment.

INFORMED CONSENT TO TREATMENT

I voluntarily consent to treatment by Connect & Beyond Physical Therapy, including via telehealth, and understand that I have the right to refuse any procedure after it has been explained to me.

COMMUNICATIONS & RECORDS RELEASE AUTHORIZATION

I authorize the release of all information acquired during the course of my treatment—including medical records, electronic media, and oral communications—to my insurance company, third-party payers, physicians, and other providers involved in my care.

I also authorize that phone messages regarding my treatment and appointments may be left with the persons or systems at the contact numbers I provide.

By signing below, I acknowledge that I have read, understand, and agree to all of the above.

Printed Name____ Date____________________

Signature____