

# Sterling Physical Therapy

1449 Hwy. 6 Suite 260  
Sugarland, TX 77478  
Phone# 281-240-3140  
Fax# 281-605-5075

[www.sterlingtherapy.com](http://www.sterlingtherapy.com)

## REGISTRATION FORM

Section I:	Patient Information	Date _____
Name: _____ I Prefer to be called: _____		
Address: _____ City: _____ State: _____ Zip _____		
Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____		
Date of Birth: _____ Social Security Number: _____		
Check Appropriate Box: <input type="checkbox"/> Minor <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Check Appropriate Box: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Spouse or Parent's Name: _____ Employer _____ Work Phone _____		
Primary Doctor: _____ Phone _____		
Referral Doctor: _____ Phone _____		
Email Address _____		

Section II	Responsible Party
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name: _____ Relationship to Patient: _____	
Address: _____	
City: _____ State: _____ Zip: _____ Phone: (____) _____	
Employer _____ Work Phone (____) _____ SSN# _____	

Section III	Insurance Information
Insurance Company _____ Ins. Co Address: _____	
Ins Co. Phone: _____	
Grp # _____ ID# _____	

Section IV	Secondary Insurance Information
Insurance Company _____ Ins. Co Address: _____	
Ins Co. Phone: _____	
Grp # _____ ID# _____	

## Important Company Policies

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial  
All  
Boxes

### Late Policy “10-minutes”

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

### 24-Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice**. Anything less will result in a **\$10 fee** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **\$10 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

### Copays are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an “Extension Request” form. This is a “promise-to-pay” form and carries a minimal fee that allows you to keep your appointment.

### No-shows are bad

If you fail to show for an appointment without notice all future appointments will be removed and a **\$10 fee** assessed to your account. You may re-schedule appointments again on a “first come, first serve basis”.

### Cell phones must be shut OFF or silent.

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

### Children requiring supervision are NOT allowed to attend sessions with you.

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly 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.

### Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form” which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

### Important Notice from the Federal Government:

“It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as “professional courtesy” and “TWIP’s - Take what insurance pays”. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089.”

***We look forward to building a relationship with you that will last a lifetime!***

# **Sterling Therapy & Rehabilitation, PLLC**

## **Financial Policy and Patient Responsibility**

**Sterling Physical Therapy & Rehabilitation, PLLC is committed to providing our patients with the highest quality care. We thank you for taking the time to read and understand our policy.**

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### **It is the Patients 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, coinsurance, 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 Provider (PCP) and/or obtain authorization for treatment form their insurance carrier prior to receiving services. Any non-covered services are the financial responsibility of the patient.**
- **To pay their co-payment at the time of service.**
- **To pay any Medicare deductible and co-insurance amounts not covered by supplemental insurance.**
- **To promptly pay any patient responsibility indicated by their insurance carrier.**
- **To facilitate in claims by payment by contacting their insurance carrier when**

### **It is Sterling Therapy & Rehabilitation, PLLC's responsibility:**

- **To provide quality medical care.**
- **To file insurance claims as a courtesy to the patient. A 60 day period will be extended for pending insurance payment, after which the patient may be held responsible for the balance.**

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### **Financial Policy Acknowledgment:**

**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 responsible for the balance on my account for any services rendered.**

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\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**

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### **Release of Medical Information and Assignment of Benefits:**

**I authorize the release of medical information necessary for filing health insurance claims for me by Sterling Physical Therapy. I also authorize my insurance carrier(s) to make payment directly to Sterling Physical Therapy.**

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\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date**



**PRE-EXAM QUESTIONNAIRE**

<b>Name:</b>	<b>Doctor:</b>	<b>Occupation:</b>	<b>Age:</b>
<b>Reason for coming to therapy:</b>			
<b>Date of Injury:</b>	<b>Date of Surgery:</b>	<b>Gender:</b>	

**PAST MEDICAL HISTORY**

<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Condition</b>	<b>Yes</b>	<b>No</b>	<b>Condition</b>	<b>Yes</b>	<b>No</b>
Diabetes			Kidney problems			Thyroid Problems		
Arthritis			Pregnant			CVA/Stroke		
High blood pressure			Allergies			Previous Fracture		
Heart Disease			Seizures			Osteoporosis		
Pacemaker or surgical implant			Metal in Body			Respiratory Problems		
Headaches			Cancer/Tumor			Other:		

**Any special tests completed for this injury? If so list the results:**

<b>MRI:</b>	<b>X-RAY:</b>	<b>CT SCAN:</b>	<b>EMG:</b>
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**MEDICATIONS:**

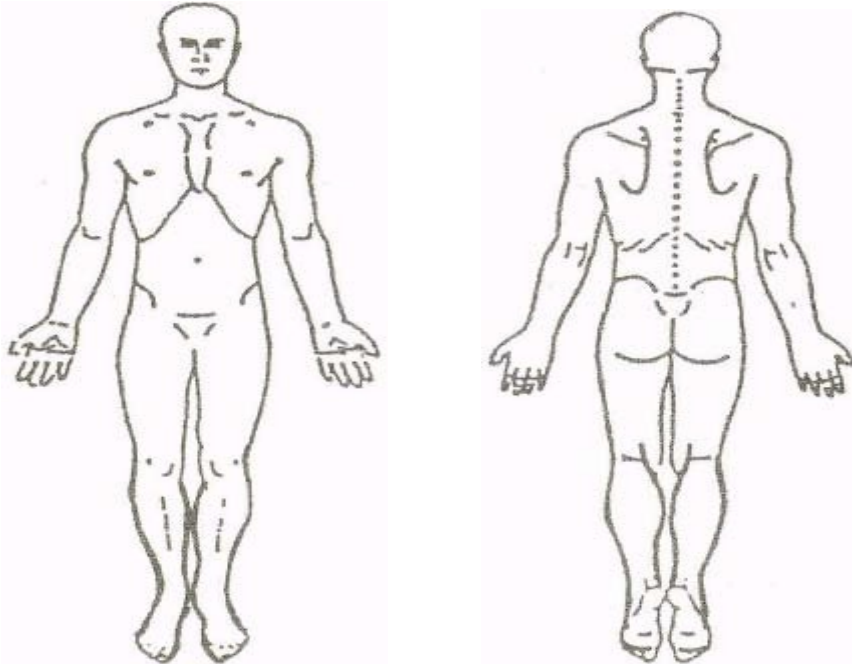
<b>Prescription/Over the Counter/Vitamins</b>	<b>frequency</b>	<b>dosage</b>

PAIN	YES	NO
Do you have Pain?		
Constant Pain?		
Night Pain?		
Numbness or Tingling?		

What activity increases your pain?

What eases your symptoms?

Please mark on the drawing where your pain is located:



PLEASE RATE YOUR PAIN ON A SCALE:

0---1---2---3---4---5---6---7---8---9---10

NO PAIN

WORST POSSIBLE PAIN

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***Sterling Physical Therapy & Rehabilitation***

1449 HWY 6, SUITE 260  
SUGAR LAND, TEXAS 77478  
PHONE# 281-240-3140  
FAX# 281-605-5075

**INSURANCE VERIFICATION FORM**

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**Patient Name** \_\_\_\_\_ **D-O-B:** \_\_\_\_\_

**S.S. #** \_\_\_\_\_

**Insurance Company** \_\_\_\_\_

**Ins. Co. Address** \_\_\_\_\_

**Ins. Co. Phone #** \_\_\_\_\_

**ID#** \_\_\_\_\_ **Grp#** \_\_\_\_\_

**PPO:** \_\_\_\_\_ **HMO:** \_\_\_\_\_

**Co-pay Amount:** \_\_\_\_\_ **Deductible** \_\_\_\_\_

**Out of Pocket** \_\_\_\_\_ **Co-Insurance** \_\_\_\_\_

**Authorization Required** \_\_\_\_\_ **Authorization#** \_\_\_\_\_

**Authorization Phone #** \_\_\_\_\_

**Treatment Code** \_\_\_\_\_ **Diagnosis Code** \_\_\_\_\_

**Visits allowed** \_\_\_\_\_

**United Healthcare Patient?** \_\_\_\_\_ **Is A.C.N. required?** \_\_\_\_\_

**A.C.N. authorization#** \_\_\_\_\_

**How many visits were authorized?** \_\_\_\_\_

**Person you spoke with** \_\_\_\_\_

**Reference#** \_\_\_\_\_

**Date** \_\_\_\_\_ **Time** \_\_\_\_\_

Assignment of Benefits to:  
Sterling Therapy & Rehabilitation, PLLC

Patient Name: \_\_\_\_\_

Insurance Policy #: \_\_\_\_\_

Insured Name: \_\_\_\_\_ Insured Date of Birth \_\_\_\_\_

Your relationship to the Insured:  Parent  Spouse  Other: \_\_\_\_\_

Claim # \_\_\_\_\_

I hereby instruct and direct \_\_\_\_\_ insurance company to pay by check made out and mailed to:

**Sterling Therapy & Rehabilitation, PLLC**  
**1449 Hwy 6, Ste. 260**  
**Sugarland, TX. 77478**

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize [COMPANY] to deposit checks made in my name.
- I authorize [COMPANY] to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Signature of Policyholder

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Claimant, if other than Policyholder

