CANYON THERAPY

Physical & Occupational Therapy

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PATIENT REGISTRATION FORM

Patient Information

First Name: _____ *Last Name:* _____

Nickname : _____ *Date of Birth:* _____ *Gender:* **M F**

Mailing Address: _____

City: _____ *State:* _____ *Zip Code:* _____

Mobile Phone: _____ *Home Phone:* _____

Email: _____

Emergency Contact

First Name: _____ *Last Name:* _____

Relationship: _____ *Phone:* _____

Federal or State of Wyoming Workers' Compensation

Date of Injury: _____ *Social Security #* _____

Claim # _____ *Claim Adjuster's Name* _____

Claim Adjuster's Phone # _____ *Employer* _____

How would you like to receive your billing statements?

☐ Email

☐ Mail

Form continues on the back.

HIPPA Consent

I have been given the right to review such Notice of Privacy practices prior to signing this consent. I understand that Canyon Therapy has the right to change its Notice of Privacy from time to time and that I may contact this clinic at any time to obtain a current copy of the notice.

Consent to Treat

I authorize Canyon Therapy to render services as deemed necessary for the care of the above-named patient.

Medical Release of Information

I authorize Canyon Therapy to release any medical information necessary to process claims.

Patient/Guardian Signature: _____ **Date**: _____

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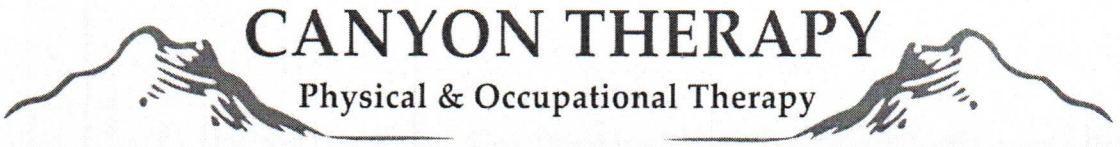
How did you hear about us?

Doctor Previous Patient Radio Social Media/Website Friend (if so, who?): _____



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544 Yellowstone Ave., Cody, WY 82414 Phone: 307-587-9789 Fax: 307-587-9787

Patient Payment Agreement:

Canyon Therapy will verify all insurance coverage based off the insurance information we are provided. You are responsible for any difference in what was quoted by your insurance company and what was actually paid. We recommend that you call your insurance carrier to gain understanding of your benefits. We will do everything in our power to obtain the necessary referrals or authorizations, however it is ultimately your responsibility to verify that all your visits are covered by referral or authorization. Any charges incurred that are not covered by your insurance become your responsibility.

I agree that if it becomes necessary to forward my account to a collection agency, I will be responsible for any attorney fees. _____ (initial)

I agree to pay monthly until the full balance of my account is paid. I understand that if I do not continue to make payments, I will be sent to collections. If I am to have any further questions or my financial status changes, I will notify Canyon Therapy immediately to discuss my options.

Canyon Therapy provides many payment options including:

- Online bill payment at *canyontherapy.com*
- Calling with credit/debit card payment over the phone at 307-587-9789
- Stopping by the office of Canyon Therapy, 544 Yellowstone Ave, Cody, WY 82414
- Mailing in payment with check or credit/debit card number
- Automatic monthly payment set up

_____ _____

Patient/Parent or Guardian Signature Date

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Cancellation & Missed Appointment Policy

It is the policy of Canyon Therapy to administer a $40.00 penalty in the event that a patient fails to show up for their appointment without giving 24-hour notice.

No call, no shows will be directly subject to the $40 fee.

Patients who are more than 10 minutes late for their scheduled appointment may have to reschedule at their therapist's discretion. Chronic tardiness can result in being discharged.

Repeated violation of these policies can result in either being discharged from care at Canyon Therapy entirely or being placed on our "Same Day Call" list. Should you be on this list, all appointments will be cancelled, and you will only be permitted to schedule if you call in the morning of the day you would like to be seen and take any open appointment that is available.

Signature: _____

Date: _____