POTOMAC
PHYSICAL MEDICINE

PATIENT REGISTRATION FORM

Welcome. Please complete the following and allow our staff to copy your driver's license and insurance card.

CONFIDENTIAL PATIENT INFORMATION

Name: *(Last, First, M.I.)*					**SSN:**			
Address:					**Date of Birth:** *MM/DY/YEAR*		**Age:**	
City:		**State:**		**ZIP:**		**Sex:**	☐ Male ☐ Female	
Email:				**Marital Status:**	☐ Single ☐ Married	☐ Separated ☐ Widowed	☐ Divorced ☐ Partnered	
Phone: ☐ Home ☐ Work			**Cell Phone:**			**Cell Carrier:**		
Preferred Contact Method?	☐ Cell ☐ Home	☐ Work ☐ Email	*Initials*	**Yes. Please send me mobile text appointment reminders** from Potomac Physical Medicine at the cellphone number provided above. I understand I am responsible for any charges or fees by wireless carrier generated by these reminders.				
Occupation:			**Employer:**					
Emergency Contact Name:			**Emergency Contact Phone:**					
Relationship to Patient:								
Primary Care Name:			**Primary Care Phone:**					
Referred to Office By:								

INSURANCE INFORMATION

Primary Insurance:						**Policy ID/Number:**	
Insurance Address:						**Group ID/Number:**	
City:		**State:**		**ZIP:**		**Insurance Phone:**	
Policy Holder's Name: *(Last, First, M.I.)*						**Relationship to Patient?**	☐ Self ☐ Spouse/Partner ☐ Parent
Address:						**Date of Birth:** *MM/DY/YEAR*	
City:		**State:**		**ZIP:**		**Phone:**	
Employer:						**Employer Phone:**	

PAYMENT OPTIONS & AUTHORIZATION

PLEASE REVIEW AND SELECT YOUR PREFERRED METHOD OF PAYMENT FOR SERVICES

☐ **Option 1 – Self Pay:** I agree to assume all responsibility and to keep my account current by paying for services when they are rendered.

☐ **Option 2 – Self-Claim:** I wish to file my claims personally. I agree to assume all responsibility and to keep my account current by paying for each visit at the time services are rendered.

☐ **Option 3 – Clinic Claim Submission:** If applicable, please bill my insurance on my behalf. I understand I am responsible for the costs of treatment at time services rendered. I authorize Potomac Physical Medicine (PPM) to act as my agent in helping me obtain payment from my insurance company. I understand that PPM will make every attempt to obtain payment from my insurance company and that payments designated as "the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I authorize the use of the use of this form and my medical records to my insurance company for insurance submissions. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date. I authorize that the payment of my insurance benefits be made directly to PPM for all services delivered. If I am paid directly I will promptly pay PPM all monies paid to me.

If option 3 is selected, please confirm and initial the following:

Statement of Non-Accident: __________ I hereby attest that the injuries/conditions for which I am seeking treatment in this office are NOT due to an auto or work accident.

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PATIENT INSURANCE PROCEDURES & RESPONSIBILITIES

If Potomac Physical Medicine is considered to be an "out-of-network" provider with your insurance company, please expect to be reimbursed at the out-of-network rate associated with your plan, after your deductible. Upon request, we can provide you with a receipt for you to submit to your insurance carrier. We highly recommend that you call your insurance provider in advance of your appointment to review and understand your coverage.

STANDARD PATIENT INSURANCE CLAIM PROCEDURES:

1. Call your medical insurance representative and ask for their policy on submitting non-participating or out-of-network claims.
2. Complete claims form required by your insurance provider. Please remember to make copies of everything for your records.
3. Mail the completed form with your itemized receipt from our office to the address on the back of your insurance card.
4. Explanation of Benefits (EOB) and/or a reimbursement check should be sent to you in the mail.

Our fees are based upon industry standards. Fees for an initial visit or new problems are typically higher than a routine follow-up visit because more time needs to be scheduled to adequately diagnose and treat a new problem. Potomac Physical Medicine bills for each modality at the time of service and costs vary depending on the type of treatment plan. Your insurance policy is an agreement between you and your insurer, not between your insurer and this clinic. Our clinic will call your insurer to verify your benefits; however, we are not responsible for your insurer's final payment and benefit determinations. For additional questions, contact your insurance provider.

INSURANCE DENIAL of PAYMENT because not deemed "MEDICALLY NECESSARY": By signing this form, you accept responsibility for payment in full to Potomac Physical Medicine for any charges for services requested by you and rendered to you that are denied by your insurance because your insurance providers/plan deems the services to be not medically necessary.

_______ *Initials* **I have read the information provided above and understand that all health services rendered to me and charged to me are my financial responsibility.**

GENERAL CLINIC POLICIES

- **MEDICAL RECORDS REQUEST:** All medical records request are provided within a 1 week from date of request. A copying fee is applied for records in the amount of $25.00. Please allow 1 week for completion.
- **FORMS AND FMLA:** If you have a complex form that needs to be completed, we would prefer to have you bring the form in at an office visit. This allows our physician's to obtain all of the required information and submit the forms in a timely fashion. If you have forms that do not require an office visit, please allow 1 week for form completion. There will be a fee for form completion in the amount of $25.00.
- **PATIENT DISMISSAL:** We rarely find the need to dismiss a patient from the practice. Reasons include, but are not limited to noncompliance, abusiveness to staff or failure to pay your bill. Outstanding balance due at the end of 30 days and sent to collections after 90 days.
- **LAB RESULTS:** Lab results will be provided in a secure message via the patient portal. If you do not choose to access the portal, you will be contacted by your physician.
- **SUPPLEMENT REFILLS AND PRESCRIPTIONS:** Most supplements are provided in one month supply increments. Supplement refills are based on individual necessity. You may be required to schedule an appointment before further refills are given. All routine prescriptions require follow up visits every 3-6 months depending on medical necessity.
- **ACUTE CARE APPOINTMENTS:** We reserve appointment times for same day/next day acute care visits. Please call as early as possible in the morning for the best selection of times for acute onset of symptoms.
- **EMERGENCIES:** If you are experiencing an emergency or are involved in an accident, please dial 911 or proceed to the nearest emergency room. Notify us of your condition when possible.
- **AFTER HOURS URGENT CARE:** If you have an urgent problem or concerns after regular office hours, you may call our office and leave a message. Your call will be returned as soon as possible. *This service is provided for established patients only* and you may be charged a $175 convenience fee above any fees associated with treatment or services rendered.
- **HOSPITAL VISITS:** We are an out-patient only office. Should you need to be hospitalized, our team will coordinate your care with a local hospitalist group at the hospital of your preference.
- **LATE ARRIVALS:** If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to our other patients. Please understand that this policy is in place to prevent our physicians from falling extremely behind during the day.
- **CANCELLATIONS, NO SHOWS, & APPOINTMENT CHANGES:** We assess a **$50 fee for regular appointments or a $75 fee for new patient appointments if 24 hours notice is not given for cancellations, no shows, or changes**. *To cancel or change a Monday appointment, please call our office by 2:00 p.m. on Friday.* If you were unable to make a scheduled appointment due to extenuating circumstances, please contact our practice immediately.

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E-COMMUNICATION POLICIES

E-COMMUNICATION: We are committed to protecting the privacy of our patients and the security of your health care information. Email is not a safe or secure method of communication for medical needs or health care. We ask all patients not to use email to communicate medical needs. If there is an emergency or urgent need for communication, call 911 or you may call the clinic at 571-982-3354.

- **PATIENT PORTAL:** Our office is equipped with a patient portal. The patient portal is a secure method of communication for prescription refill request, non-urgent medical questions, lab and diagnostic imaging results, follow up questions, etc. The patient portal allows you to make additions to your health records, medications lists, and view past summaries. When you register for access, you will receive a message asking you to set up a username and password. If you have difficulty with the portal, please contact the office and our staff will walk you through completing the registration. Patient portal messages will be returned within 24 hours.
- **EMAIL: staff@potomacphysicalmedicine.com** is used for new patient appointment and general office questions. Due to privacy laws, it is not to be used to seek medical advice, ask questions about new symptoms or concerns, or for highly confidential information or for concerns that require immediate action. We will normally respond to non-urgent messages or inquiries within 24 hours, but no later than 3 business days after receipt.

By signing this form, I authorize Potomac Physical Medicine to leave a detailed message regarding my medical care and/or appointments at the following number and email address:

Phone: ☐ Mobile ☐ Home ☐ Work		**Email:**	

CREDIT CARD AUTHORIZATION

It is our policy to maintain a valid credit card on file. **We will not charge this card without the card holders authorization,** except for the circumstances outlined in the GENERAL POLICIES SECTION on page 2 of this form.

Name on Card: *Print*		**CVV (3 digits):** *Back of card*	
Credit Card Number: *Print*		**Expiration Date:** *MM/YEAR*	
Signature:		**Date:** *MM/DY/YEAR*	

I certify that I have read, understand and agree to Potomac Physical Medicine's (PPM) registration form and policies. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to PPM all money to which I am entitled for medical expenses related to the services performed from time to time by PPPM, but not to exceed my indebtedness to PPM. I authorize PPM to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. I choose to receive communications from PPM by text or e-mail at the number or address stated above, including but not limited communications about appointments, treatment, and payment.

Patient Name or Legal Representative: *Print*		**Date of Birth:** *MM/DY/YEAR*	
Signature:		**Date:** *MM/DY/YEAR*	

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