NEWGEN

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name	First Name	M.I.	Nickname
Date of Birth	Social Security Number	Gender	
Mailing Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employment Status	Employer/School		
Marital Status	Race (Optional)		
E-mail Address			

GUARANTOR OR SUBSCRIBER OF INSURANCE INFORMATION

Primary Insurance Company			
Relationship to Patient ☐ Self (If self, skip to Insurance Information) ☐ Spouse ☐ Parent/Guardian ☐ Other			
Last Name	First Name	M.I.	
Date of Birth	Social Security Number	Gender	
Mailing Address	City	State	Zip
Home Phone	Cell Phone	Work Phone	
Employment Status	Employer		

OTHER INSURANCE INFORMATION

Other Insurance Company		
Subscriber Name	Subscriber Birthdate	Subscriber Social Security Number
Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other		

HOW DID YOU HEAR ABOUT US?

☐ Family/Friend ☐ Doctor ☐ Social Media ☐ Other: _____

NEWGEN

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT INFORMATION			
Patient's Physical Address	**City**	**State**	**Zip**
(1) Emergency Contact Name	**Relationship**		
Physical Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Work Phone**	
(2) Emergency Contact Name	**Relationship**		
Physical Address	**City**	**State**	**Zip**
Home Phone	**Cell Phone**	**Work Phone**	
Nearest Fire Department			
Nearest Police Station			

CONSENT TO COMMUNICATE TO OTHERS

If I choose to have my medical information communicated to individuals other than myself, I must do so by completing and signing the authorization below. I do hereby authorize NEWGEN to release my medical information to the person/persons named below

Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**
Name:	**Relationship:**	**Phone:**

Patient or Responsible Party Name: _____

Signature of Patient or Responsible Party: _____ Date: ____/____/____

NEWGEN

PHYSICAL THERAPY ATTENDANCE POLICY (Please read thoroughly)

NEWGEN strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are more than 15 MINUTES LATE for your appointment and fail to notify us, treatment may be cancelled, and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- ALL PATIENTS, regardless of insurance/third party payor, will be charged a $15 SAME DAY/LATE CANCELLATION FEE for each late-cancelled and a $25 NO-SHOW FEE for each no-show appointment. **THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.**
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.

Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits. We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All the staff at NEWGEN appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all your goals.

Patient or Responsible Party Name: _____

Signature of Patient or Responsible Party: _____ Date: ____/____/____

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS

I hereby authorize NEWGEN, 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 NEWGEN to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messaging. I am assigning my therapy benefits to NEWGEN for the services in which I receive and authorize my insurance carrier to make payments to NEWGEN on my behalf. NEWGEN reserves the right to seek reimbursement from all 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 NEWGEN before they are released, regardless of requestor. NEWGEN 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 NEWGEN 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, "Releases") 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 Lease Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releases or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt By signing this form, you acknowledge that you have been offered a copy for review of NEWGEN's 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 support@newgen.com

FINANCIAL RESPONSIBILITY

In consideration for services to be provided, I consent to pay NEWGEN all amounts that are due or owing for services provided and not paid by Medicare, a third-party insurance plan or payor, or other source on my behalf for services so rendered. In the event, it is necessary to refer this account to a collection agency or an attorney, the undersigned further agrees to pay all reasonable costs of collection, including reasonable attorney fees.

I acknowledge that I have read the above information and accept its contents.

Patient or Responsible Party Name: _____

Signature of Patient or Responsible Party: _____ Date: ____/____/____

NEWGEN

INFORMED CONSENT FOR TELEHEALTH PHYSICAL THERAPY

1. I understand that my health care provider wishes me to engage in a telehealth consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
 (1) omit specific details of my medical history/physical examination that are personally sensitive to me;
 (2) ask non-medical personnel to leave the telehealth examination room: and or
 (3) terminate the consultation at any time.
5. I have had the alternatives to a telehealth consultation explained to me, and in choosing to participate in a telehealth consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telehealth consulting specialist is to advise local emergency responders such as fire department or police department as well as emergency contact and that the specialists responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

☐ That I have read or had this form read and/or had this form explained to me
☐ That I fully understand its contents including the risks and benefits of the procedure(s).
☐ That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient or Responsible Party Name: _____

Signature of Patient or Responsible Party: _____ Date: ____/____/____