SIMIO
Health Services, PLLC
CLIENT REGISTRATION
(PLEASE COMPLETE ALL AREAS TO THE BEST OF YOUR ABILITY)

PERSONAL INFORMATION

Name: _____
Last, First MI

Date of Birth: / /
mm / dd / yyyy

Email: _____

Phone number: Home ( ) Cell: ( )

SSN: - -

Would you like appointment Reminders? ____Yes ____No (Please Select)

if Yes: ____ Text ____ Email (Please Select)

Carrier: _____Verizon ____ TMobile _____Sprint ____ Boost _____ATT ____ Other: _____

Address: _____
Street City State Zip

Employer: _____
Name

Work Related: Yes / No (Please Select)

EMERGENCY CONTACT

Name: _____
Last, First

( ) Phone Number

Relationship: _____ Spouse _____ Parent _____ Friend ____ Other: _____

PHYSICIAN/REFERRING PROVIDER

Primary Care Dr: _____
Last, First

Office Name: _____ Location

Referring Provider _____
Last, First

Office Name: _____ Location

_____ Same as above

INSURED/RESPONSIBLE PARTY/GUARANTOR (LEAVE BLANK IF SAME AS PATIENT)

Guarantor/ Policyholders Name: _____
Last, First

Home ( ) Mobile( ) Phone Number

Relationship: _____ Self _____ Spouse _____ Parent _____ Other:

Date of Birth: / / mm/dd/yyyy

SSN: - -

Address: _____
Street City State Zip

SIMIO

Health Services, PLLC

FINANCIAL POLICY / PAYMENT ASSIGNMENT AND GUARANTEE

SIMIO Health Services firmly believes that a good patient relationship is based on understanding and communication. Questions about our financial policy or payment arrangements should be directed to the business office.

We participate with a variety of insurance plans. If you are a member of one of these plans, our business office will submit claims for services on your behalf. It is YOUR responsibility to:

- Provide SIMIO with current insurance information (including your SSN) and bring your most up to date insurance card and photo ID to your first appointment.
- Be prepared to pay your Co-Pay, Co-Insurance, or service charge at each visit.
- Pay any balance, including your deductible, or any amount not covered by your insurance plan.
- Provide any workers compensation or accident related coverage information (including claim number) so that SIMIO can bill the proper payor for your services.

Patients with outstanding balances will receive monthly statements. Payment of the outstanding balance is expected within 30 days of receipt of the statement. Patient balances over 45 days will receive letters reminding of the unpaid balance. If there is a patient balance over 90 days, we will contact you directly about payment options.

Certain services and therapeutic modalities require additional service charges. Your therapist will explain the necessity and service charge associated with each modality prior to administering the service. Payment for these services is due at the time of service.

The parent or guardian of any patient who is a minor must sign this document. The parent or guardian is responsible for payments due at the time of service.

Assignment: I authorize release to any third party, such as insurance company or governmental agency, any medical information when such material is required for consideration or payment. I assign all payments for medical services for myself and/or for my dependent to SIMIO Health Services, PLLC. I agree to pay any charges not covered by my insurance for the patient listed.

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I understand that I have the right to authorize additional people to discuss my medical records which are otherwise protected by HIPPA. Please note that your insurance company, workers compensation carrier or employer, and referring physician are already listed as authorized.

I hereby authorize the release of any protected health information by SIMIO Health Services, PLLC to the **authorized designees** listed below:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

X

Patient name (Print)	Signature of responsible party	Date

SIMIO
Health Services, PLLC
MEDICAL HISTORY

Name:		DOB: / /
	Last, First	mm/dd/yyyy
Reason for your visit:		Auto: Yes / No Work: Yes / No
	Diagnosis, Area of concern, What would you like us to address?	Circle if appropriate
Onset Date:		Injury yes / No
	When did your symptoms begin?	

Are you currently receiving any other care for the condition listed above?	Yes / No	Please List all Medications and Doses: (__ I Have List)
Have you ever received physical therapy for this same condition in the past?	Yes / No	
Have you received physical therapy for any other conditions in the past 12 months?	Yes / No	
At the present time, how would you describe your overall health? Circle one:	Excellent Very Good Good Fair Poor	
—Please describe why you feel this way?		

DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

(Check the box for YES, leave blank for NO)

☐	Arthritis	☐	Diabetes (Type: 1 or 2)	☐	Headaches
☐	Osteoporosis	☐	Anemia	☐	Head Injury / Concussion
☐	High Blood Pressure	☐	Sensitivity to Heat / Cold	☐	Hernia
☐	Low Blood Pressure	☐	Swollen ankles / Legs	☐	Kidney / Bladder problems
☐	Heart Disease	☐	Seizures / Epilepsy	☐	Previous Surgery
☐	Pacemaker	☐	Metal / Surgical Implant	☐	Hearing Loss
☐	Vascular disease	☐	Cancer / Tumor	☐	Depression
☐	Stroke	☐	Recent weight Loss / Gain	☐	Anxiety
☐	Asthma	☐	Current infection	☐	Substance Abuse
☐	Shortness of Breath	☐	Tuberculosis	☐	Currently taking Meds
☐	Chronic Cough	☐	Currently Pregnant	☐	Corrected vision
☐	Allergies	☐	Hepatitis	☐	Dental appliance/splint
☐	Prone to Fainting	☐	Thyroid Problems	☐	Sleep Apnea
☐	Snoring	☐	Difficulty sleeping	☐	Other (Please describe)

(OTHER SIDE)

SIMIO

Health Services, PLLC

CONSENT FOR TREATMENT:

I hereby voluntarily consent and give authorization to receive treatment at SIMIO Health Services, PLLC. I permit its employees and all other persons caring for me to treat me in ways that they judge to be beneficial to me. I understand that this care may include evaluation, testing, and interventional services. No guarantees have been made to me about the outcome of this care.

Initial: _____

PATIENT INFORMATION:

I have been provided, read, and fully understand SIMIO Health Services Notice of Privacy Practices. I understand that SIMIO Health Services may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have a right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the company in writing. I also understand that SIMIO Health Services will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent for the use of my personal health information for the purpose noted in SIMIO Health Services Notice of Privacy Practices. I understand that I retain the right to revoke consent by notifying the company in writing at any time.

Initial: _____

RECOGNITION OF RIGHTS REGARDING STUDENTS AND OBSERVERS:

I understand that SIMIO Health Services is a teaching facility with affiliation to many area schools including GVSU's DPT program. At various times of the year, students will be present during my treatment and may provide care under the direction and supervision of a licensed physical therapist. This is necessary in order for students and physical therapists to receive excellent training and to continue SIMIO's mission to provide the highest quality care. I have the right an option to a private treatment session without a student or observer present and/or have the right to have the observer to be present in the session but not be physically involved in my treatment. This request will be voided to the clinic or business director and/or your physical therapist at any time during your visit or episode of care.

Initial: _____

BENEFIT VERIFICATION:

The information (benefits, limitations, deductibles, co-pay, co-insurance, etc.) obtained by SIMIO Health Services, from your insurance company is limited. For this reason, any explanation of benefit obtained or discussion of potential cost is to be considered an estimate and not a certification of benefits or a guarantee of payment. Determination of insurance payment and patient responsibility for services rendered will be finalized by your insurance company per your individual policy.

I understand that my health and accident insurance policies are an agreement between me and my insurance company, NOT between my insurance company and SIMIO Health Services. I understand that SIMIO encourages that I contact my insurance company directly to verify all actual benefit information related to my care at SIMIO including limitations, deductibles, co-pay, and co-insurance. I understand that SIMIO Health Services has no control over the contractual obligations between me and the insurance policy I selected.

Initial: _____

CONSENT SIGNATURE:

I [undersigned], have provided truthful responses and have read and agree to the information provided within.

Patient name (Print)	× Signature of responsible party	Date

SIMIO
Health Services, PLLC

USE OF EMAIL AND ELECTRONIC FORMS OF COMMUNICATION

I understand that my voluntary use of email, text messaging, and other electronic forms of communication do not guarantee my privacy and are not HIPPA compliant. I waive my right to the privacy of the PHI content transmitted when I elect to use these forms of communication with SIMIO staff for healthcare and scheduling related content.

Initial: _____

RESTORATIVE WELLNESS SERVICES AGREEMENT

(Applies only to election to receive Restorative Therapy Services)

If I have selected restorative physical therapy services at SIMIO, I recognize that there is a difference between regional/conditional physical therapy and restorative wellness services. I acknowledge that restorative services are directed at the proper generation of whole-body motion, respiration, and postural control, as well as the possible limitations to these areas. While I may have pain or injury that is regional, I am electing to receive restorative services at SIMIO with the goal of restoring or improving my wellness via body awareness and movement control as discussed with my restorative physical therapist.

I have been informed of the following obligations:

- Restorative physical therapy is a wellness service that is considered a non-covered service by insurance companies.
- Wellness services conducted by a physical therapist are not limited by referral, frequency, or duration stipulations in the State of Michigan and I may elect to receive wellness services without limitation so long as the services are not billed to insurance companies for reimbursement. For this reason, SIMIO will not offer insurance billing for restorative physical therapy services.
- The State of Michigan's regulations on direct access to physical therapy services also requires me, the consumer of restorative wellness services, to abstain from submitting insurance claims for restorative services provided at SIMIO.
- Health Savings Accounts (HSA) and Flexible Spending Accounts(FSA) are funding sources that are likely eligible for use for all SIMIO products including restorative wellness services. Your insurance company or fund administrator may require substantiation that the services rendered were provided by an appropriate provider, in an appropriate facility, and possibly with the written recommendation or referral from a primary care provider (MD, DO, FNP, PA, or other qualified practitioner). I understand that it is my obligation to obtain and satisfy the requirements of the funding source.

	X	
Patient name (Print)	Signature of responsible party	Date

HOW DID YOU LEARN ABOUT SIMIO?

_____

_____

IS THERE SOMEONE WE CAN THANK?

_____

_____