

**ORTHOPAEDIC ASSOCIATES OF WAUSAU / PRO PHYSICAL THERAPY & HAND CENTER
PATIENT REGISTRATION FORM**

1. PATIENT INFORMATION

Name _____ Maiden/Former Name _____

Social Security No _____ Date of Birth _____ Employer _____

Email Address _____ Do you want Portal Access: Yes No

Race: White Black or African American Asian Native Hawaiian or Other Pacific Islander American/Alaskan Native Unknown

Ethnicity: Latino/Hispanic Not Hispanic or Latino Other Unknown Marital Status: _____ Gender: _____

Primary Care Physician _____ Facility: _____

Do you make your own healthcare decisions? Yes No

If no, who is your POA? _____

Relationship _____ Telephone Number _____

2. INSURANCE COVERAGE INFORMATION

**ALL patients
must answer** →

Are you being seen for a work-related injury/condition? _____Y _____N

At this time, I, _____, represent and warrant that I

(Print Your Name)

(DO) or (DO NOT) have Medicaid coverage.

Circle One – If unmarked, default is a representation that you do not have Medicaid currently. If you are completing this form on a system where you cannot circle one, please inform the staff immediately if you have Medicaid health insurance coverage.)

3. ASSIGNMENT AND RELEASE OF INFORMATION

MEDICARE: I request that payment of authorized Medicare benefits be made to Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient/Guardian _____ Date _____

ALL PATIENTS: I hereby authorize the offices of Orthopaedic Associates of Wausau and/or PRO Physical Therapy & Hand Center of Wausau (OAW/PRO), to release any medical information required during the course of examination and treatment to my insurance company(ies), and I permit payment to OAW/PRO from my insurance for any benefits due for their services rendered. I permit a photographic or other facsimile of this authorization to be used in place of the original. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per insurance benefits.

Patient/Guardian _____ Date _____

4. PRESCRIPTION HISTORY

I agree that OAW/PRO may request and use my prescription medication history from other health care providers or third-party pharmacy benefit payors for treatment purposes.

Patient/Guardian _____ Date _____

5. PATIENT COMMUNICATIONS

I authorize OAW/PRO to contact me at the phone number(s) and e-mail address I provided during my registration as a patient. OAW/PRO may contact me via phone call, text message, or e-mail. The messages may be automated, autodialed, prerecorded calls and/or texts to communicate appointment reminders, notifications regarding the availability of path or lab results, billing and collection information. I understand that I am not required to give the consent as a condition of receiving medical care or goods. I may revoke my consent to receiving such calls and/or messages at any time by contacting OAW/PRO in writing, by phone, or by following the automated prompts provided in those messages.

Patient/Guardian _____ Date _____

6. PRIVACY

I acknowledge I have been provided or offered a copy of the Privacy Practices of Orthopaedic Associates of Wausau/PRO Physical Therapy and Hand Center (OAW/PRO). These can also be accessed on our website at oaw-ortho.com.

Patient/Guardian _____ Date _____

DISCLOSURE/DISCLAIMER OF OWNERSHIP

PRO Physical Therapy & Hand Center of Wausau is a division of Orthopaedic Associates of Wausau, and is fully owned and operated as part of their comprehensive services that they deliver for their patients. As an OAW patient, there is no obligation for you to receive physical therapy and occupational therapy services at our clinic, and as always, you have the right to choose any rehab provider or location that you desire.

Orthopaedic Associates of Wausau and PRO PT complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.



Please review our office policies regarding financial responsibility and prescription refills. You may view a copy of these policies at our reception desk, on our website at www.oaw-ortho.com or using the QR code below. You can request a printed copy of these policies from our reception team.



Please initial each line item below:

_____ I have reviewed the OAW/PRO Financial Policy.

_____ I have reviewed the OAW Prescription Refill Policy.

Please sign and date that you understand and acknowledge these policies.

Patient/Guardian _____

Date _____