



PATIENT REGISTRATION

PATIENT INFORMATION – Please Print

Patient Name (Last, First, MI):		DOB:	AGE:
Address:		SSN:	
City, State, Zip:		Gender:	
Home Phone:	Cell Phone:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
E-mail Address:		Marital Status:	
Authorized Communication Method (check all that apply): <input type="checkbox"/> Mail <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> E-mail		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
Employer Name:		Work Phone:	
Employer Address:		May we contact you at work?	
Employer City, State, Zip:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse Name:		Spouse SSN:	

EMERGENCY OR GUARDIAN CONTACT INFORMATION

Emergency Contact Name:	
Phone:	Relationship to Patient:
Is the patient under 18 or do they require a legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Guardian Name:	DOB:
Guardian Employer:	
Phone:	Relationship to Patient:

INSURANCE INFORMATION

If you are not the Policy Holder, please fill out completely:	Primary	Secondary
Insurance Company Name		
I.D. / Policy Number		
Group Number		
Policyholder Name		
Policyholder Address (if different than patient)		
Policyholder Relationship to Patient		
Policyholder Date of Birth		
Policyholder Social Security #		
Reason for visit:	<input type="checkbox"/> New Illness / Pain / Injury <input type="checkbox"/> Recurrent Illness / Injury <input type="checkbox"/> Sports Injury <input type="checkbox"/> On-the-Job Injury <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other: _____	
Date of Accident / Injury:	Referring Physician:	
Claim Number:	Primary Physician:	
Adjustor's Name:	Approximate Date of Onset: ____ / ____ / 20__	
Adjustor's Phone:	Area(s) of body affected:	

Patient Signature

Parent/Guardian Signature
(Required if patient is under 18)

Date



AUTHORIZATION & GUARANTEE

Patient Name (Last, First, MI):	DOB:
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CONSENT FOR TREATMENT: "I understand I have the right to choose my physical therapy provider and have chosen this facility and hereby consent to all treatment which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Physical Therapy Associates, Inc. I further acknowledge that a copy of this agreement shall be valid as the original."

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation patients): "In consideration of services rendered to me by Physical Therapy Associates, Inc., I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with Physical Therapy Associates, Inc. become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees/costs associated with resolving my account."

INSURANCE BENEFITS (if applicable): As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

MEDICARE (if applicable): "I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

ASSIGNMENT OF BENEFITS: "I hereby give my health plan lifetime authorization to pay benefits directly to Physical Therapy Associates, Inc. and any assisting physicians for services rendered. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider Physical Therapy Associates, Inc. a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient."

RETURNED CHECKS: We are happy to accept your personal check, however, if your check is returned to us for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: "I consent to allow Physical Therapy Associates, Inc. to use and disclose my protected health information (PHI) within Physical Therapy Associates, Inc. to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services, and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing." By signing below, I hereby authorize Physical Therapy Associates, Inc. to receive protected health information about me from the following people.

Name:	Relationship to Patient:

NOTICE OF PRIVACY: "I acknowledge that a copy of the Notice of Privacy Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."

WAIVER AND RELEASE: "I hereby release, discharge and acquit Physical Therapy Associates, Inc., its agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

AUTHORIZATION & GUARANTEE:

I acknowledge that I have reviewed, understand and agree to the content & terms described herein.

PATIENT'S RIGHTS AND RESPONSIBILITIES:

I acknowledge I may request to receive a copy of the Patient's Rights and Responsibilities outlined in the Authorization for Use and Disclosure of PHI & the Authorization & Guarantee.

PRIVACY NOTICE:

I acknowledge that I may request to receive a copy of Physical Therapy Associates, Inc. Privacy Practices.

Patient or Parent/Guardian Signature (Required if patient is under 18)

Date



ADDITIONAL INFORMATION

Patient Name (Last, First, MI):

DOB:

Is there any other area besides the one listed on your order that causes you pain or discomfort that you would like to discuss with your physical therapist today? Yes No

If yes, what body part? _____

Please provide us with a brief description of symptoms: _____

