

date / /	patient registration	patient #
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patient information

how have you heard of us?	<input type="checkbox"/> physician	<input type="checkbox"/> friend	<input type="checkbox"/> yellow pages	<input type="checkbox"/> health plan	<input type="checkbox"/> drive by	<input type="checkbox"/> web			
last name			first name & mi						
address					apt. #				
city			state	zip					
home phone #			work phone #						
cell phone #			email						
sex	m	f	marital status	m	s	employed	ft student	pt student	other
birth date		patient s.s. #		occupation		employer			
referred by			office name		office phone				
responsible party (full name)					relationship to patient				
responsible party s.s. #				responsible party d.o.b.					
person to contact in case of emergency					phone #				
relationship to patient									

insurance information

medicare or primary insurance	secondary insurance
policy holder (complete name)	policy holder (complete name)
relationship to patient	relationship to patient
group #	member #
group #	member #

workers' compensation information

date of injury
employer when injured
employer's address
city, state, zip
employer's phone #
contact person
work comp insurance carrier
address
city, state, zip
work comp claim #
open / accepted y n managed care y n
adjuster phone #

auto accident information

date of auto accident
auto insurance company
address
city, state, zip
agent
agent phone #
name of insured
policy #
claim #
open / accepted y n
adjuster phone #

for office use only	illness	wc	m / d / y	dx code #1	dx code #2	dx code #3	md date
	hi	auto					

ASSIGNMENT OF BENEFITS: I hereby authorize and direct any insurance company to pay the proceeds of any benefits due me for services rendered by MultiCenter Physical Therapy, LLC directly to the provider. A copy of this can be considered as an original for insurance purposes. _____

initials

KNOWLEDGE AND CONSENT TO TREATMENT: I understand the diagnosis of my problem and consent to MultiCenter Therapy, LLC to render the appropriate treatment as prescribed by my physician. _____

initials

RECEIPT OF NOTICE OF PROTECTED HEALTH INFORMATION: I received written notice of my privacy rights.

initials

RELEASE OF INFORMATION: I authorize MultiCenter Physical Therapy, LLC to release to my referring physician and insurance company any information including PT evaluation, medical history and records of treatment. For workers' compensation claims, I understand this information may also be released to my employer. _____

initials

RESPONSIBILITY OF AGREEMENT: I acknowledge and understand that I am responsible for the allowed charges for services rendered to me or my dependent. I request that my bill be submitted to my insurance company. If for any reason any portion of my allowed bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill. I understand that obtaining required authorization for physical therapy (and/or supplies) may be my responsibility, as is any unpaid balance if this is not done. I acknowledge that in the event my account becomes past due and is referred to an outside collection agency or attorney, I will be responsible for the collection costs (up to 33 percent of balance due) along with reasonable attorney fees and court costs incurred by this office. _____

initials

SIGNATURE X _____ DATE _____

Returning Patients :

I have reviewed the information on the reverse side and I agree that it is true and correct. I have acknowledged the above 5 statements and agree to give my consent.

SIGNATURE X _____ Date _____

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