Patient Registration Form

First Name________________ MI_____ Last Name________________

Date of Birth __________ Social Security # __________

Gender
☐ Male ☐ Female

Address ____________________

		OK To Call	Best Time To Call
Home Phone	__________	☐	__________
Work Phone	__________	☐	__________
Cell Phone	__________	☐	__________

As a courtesy, we remind each patient 24 hours prior to their appointments. How shall we contact you?

☐ Phone call ☐ Text Message ☐ E-mail ☐ No reminder needed

Phone provider ________

Email Address ____________________

Marital Status
- ☐ Married
- ☐ Single
- ☐ Other

Employment Status
- ☐ Full-Time
- ☐ None
- ☐ Part-Time
- ☐ Retired
- ☐ Active Military

Student Status
- ☐ Full-Time
- ☐ Part-Time
- ☐ None

Patient Employer________________
Address________________
Phone ________________
Occupation________________

Spouses Employer________________
Address________________
Phone ________________
Occupation ________________

How did you hear about us?____________________

Emergency Contact________________ Phone # __________

Prescribing MD________________ Phone # __________

Attorney Name________________ Phone # __________

Payment Arrangements

Payment is due at the time of visit. Please let us know how you will be paying for your visits.

☐ Check
☐ Cash

☐ Credit Card #______________________________ Exp.__________

☐ HSA Card #______________________________ Exp.__________

Zipcode ____________________ Code __________

Receipt Preference ☐ Mail ☐ In hand ☐ No receipt

I authorize transfer of all unpaid and undisputed charges to my credit card after 30 days from my last date of service.

Authorization to Release/Obtain Information/Benefit Assignment

I hereby authorize the release of any and all information to my physician's office, insurance company, employer or other appropriate third party providers, as required, pertaining to treatment rendered to me by Preneta Physical Therapy. Further, I authorize Preneta Physical Therapy to obtain required information from my physician's office, insurance company, employer, or other third party providers. Correspondence may be made via mail, email, facsimile, EMR (electronic medical record system), and/or telephone. I here by assign all medical benefits to include major medical benefits, to which I am in titled including Medicare, Private insurance's, and third party payers to Preneta Physical Therapy. A photo copy of this assignment is to be considered as valid as the original.

Consent to Treatment

I hereby consent to treatment as prescribed by my physician or under Direct Access for Physical Therapy, its employees, or representatives.

Notice of Office Procedures

I have been made aware and fully understand:

I understand that I am financially responsible for services rendered by Preneta Physical Therapy, including charges left uncovered by my insurance company.

I must keep all scheduled appointments and understand that a fee of $50 may be charged for appointments missed if not canceled by 5:00pm the evening before my scheduled apointment. These charges are not reimbursed by any insurance carrier.

A $35 service fee will be imposed for any check returned for any reason.

In the event my account is referred to third part collections or small claims court, I will be responsible for all charges up to the statutory limit.

Notice of Privacy Practices

I hereby acknowledge that a copy of the current notice is posted in the reception area, and that I may request a copy of any amended Privacy Practice at anytime.

____ ______________

Patient or Guardian's Signature **Date**

Relationship of Guardian to Patient ______________________________