



SPORTS AND PHYSICAL THERAPY – PATIENT REGISTRATION

Patient Name: _____ Date: _____

Address: _____

Street City State Zip

Gender: M or F Email address: _____

Date of Birth: _____ Social Security number: _____

Marital Status: _____ Spouse: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Diagnosis (What are we treating you for?): _____

Date of Injury/Symptoms: _____ Have you had Physical Therapy for this before?: Y or N
If Yes, when and with whom?: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

INSURANCE INFORMATION – Please complete entire section

Insurance Carrier: _____ Phone #: _____

Policy #: _____ Group #: _____

Name of Subscriber to Policy: _____ Date of Birth: _____

Relationship to Subscriber: (Please circle) Spouse Parent/Child Guardian Other

Subscriber Address (if different than Patient): _____

Street City/State/Zip

Secondary Insurance Carrier: _____

Policy #: _____ Group #: _____

Subscriber: _____ Date of Birth: _____ Relationship: _____

****If you have MEDICARE, are you also receiving care from a Home Health Agency? Y or N**

Agency Name: _____ Phone #: _____

If your injury is Work or Motor Vehicle Related, you MUST complete this section:

Is your injury work related?: Y or N Is your injury related to a motor vehicle accident?: Y or N

Date of Injury/accident: _____

Work/Auto Insurance Carrier: _____

Adjuster Name: _____

Claim #: _____ Adjuster's Phone #: _____

Insurance Co Billing Address: _____

Street City/State/Zip

Please read and sign below.

1. I hereby assign to Sports and Physical Therapy Associates all payments for Medical Services rendered to my dependents or myself.
2. I understand that I am financially responsible for charges not covered by my insurance carrier.
3. I understand that I am responsible for all referrals, authorizations and co-payments. Co-payments are due at the time of visit. We will not bill patients or secondary insurances for your co-payment.
4. If you are a Medicare patient, you must provide us with an updated prescription from your physician.
5. If your injury is Work or Auto related, you must complete the front of this form in its entirety. Your claims will be submitted directly to the Insurance Carrier. **WE WILL NOT BILL YOUR ATTORNEY.** Copies will be forwarded to your attorney upon written request.
6. I have received the "NOTICE OF PRIVACY PRACTICES" for Sports and Physical Therapy Associates.
7. ***Cancellation/No Show Policy:***

Providing us with 24-hour notice allows us the opportunity to call patients that are on a cancellation list and offer them the available times. If an appointment is canceled less than 24 hours in advance or is a no show a fee of \$35 will apply.

8. ***Co-payment Agreement:***

We ask that you present your co-payment to us at the start of each visit. Payments are accepted in the form of cash, check or credit card (Visa and MasterCard, or Discover only). If your co-payment increases during the course of your therapy or the co-payment amount indicated on your card is not current, you will be responsible for any additional amounts owed.

** Please sign below. If you are under 18 years of age, a parent or guardian must sign. **

I have read the above and understand that I am currently responsible for a

\$ _____

co-pay at the time of each visit.

Signature: _____

Name Printed: _____

Date: _____

Person to notify in case of emergency

If a student, please fill in your permanent address.

Name: _____ **Relationship:** _____

Address: _____
Street City State Zip

Home Phone #: _____ **Work Phone #:** _____

