

REGISTRATION FORM

Patient Name _____ Address _____

City _____ State _____ Zip Code _____ Telephone (____) _____

Cell Phone _____ May we leave a message? Home ____ Work ____ Cell ____ All ____ Please check all that apply

Social Security No. _____ Marital Status (S M W D) Birthdate ____/____/____ Age _____

Sex _____ Height _____ Weight _____ E-Mail Address _____

Your Occupation _____ Employed By _____ Telephone (____) _____

Name of SPOUSE or PARENT _____ Occupation _____ Telephone(____) _____

Name and telephone number of a relative or friend to contact in case of emergency: _____

Name of referring physician _____

Problem you are here for? _____ Date symptoms began _____

(FEMALE) Is it possible you are pregnant? YES NO

Past surgical procedures or major injuries related to your current condition: _____

Have any tests such as xrays or MRIs been done for the condition? Yes ____ No ____ If yes please list test performed and the location of the records.

Past medical illness: (circle) cancer, heart problems, high blood pressure, ulcers, or other _____

Are you taking any medications? YES NO If yes, please list: _____

Are you sleeping well at night? YES NO

Do you have any allergies? YES NO If yes, please list them _____

Does your Insurance Company require a **DR.'S REFERRAL** for Physical Therapy? YES NO

Does your Insurance Company require a **PRIOR AUTHORIZATION** for Physical Therapy? YES NO

FAILURE TO KEEP APPOINTMENTS

* To fulfill our healthcare mission, and to optimize individual patient outcomes, there must be shared responsibility between the patient and the therapy staff. Patients who chose to repeatedly miss scheduled therapy appointments minimize their healing potential and deny time slots for others who wish to have care. For these reasons, patients who miss 3 consecutive treatments without a timely excuse and notification to Spine & Sport will be discharged from therapy with a statement of discharge sent to their physician and/or medical case worker. Spine & Sport will also charge a \$46.00 fee for the third missed appointment. This policy is incorporated to protect all patients and not compromise those in need of our services.

INJURY INFORMATION

Was this an injury? At Work Yes _____ No _____ Date _____

Auto Accident Yes _____ No _____ Date _____

School Injury Yes _____ No _____ Date _____

INSURANCE INFORMATION

MUST BE FILLED OUT COMPLETELY ALONG WITH A COPY OF YOUR INSURANCE CARD(S)

Any charges not covered by insurance are payable by the patient regardless of the reason. This includes but is not limited to deductibles, co-payments, denial, etc. Statements are sent after your insurance pays or denies, and are payable upon receipt.

- We expect full cooperation from the patient in acquiring payment from the insurance company. Please notify our office of any information that would affect the status of your account. The patient agrees to pay for any supplies not covered by the insurance company and also any balance determined to be the patient's responsibility, in a timely manner.
- Having a health insurance plan does not relieve you from full responsibility of payment. Your coverage is a contract between you and your carrier. Your physical therapy charges are between yourself and Spine & Sport. We will bill the carrier(s) as a courtesy to you. **** PLEASE NOTE** KNOWING YOUR HEALTH CARE PLAN BENEFITS IS ULTIMATELY YOUR RESPONSIBILITY. ANY INFORMATION WE OBTAIN FOR YOU IN REGARDS TO COVERAGE IS NOT A GUARANTEE OF PAYMENT OR COVERAGE.**
- Leaving information blank on your registration form may result in your account being treated as "private pay" with no insurance carrier billed and services paid each day by the patient.

1st Insurance _____ Subscribers Name _____ Subscribers D.O.B. ___/___/___

Subscribers Empolyer _____

2nd Insurance _____ Subscribers Name _____ Subscribers D.O.B. . ___/___/___

Subscribers Employer _____

WORKERS COMPENSATION

If this was an injury at work, was it reported ? YES NO Claim Number _____

Workers Compensation Ins . _____ Address _____

Phone Number _____

Contact Person/ Case Worker _____

*Workers compensation claims that are denied can be billed to your health insurance automatically once we receive a written denial. You must provide carrier information on your insurance company in order for us to do so. Failure to provide this information will result in payment in full by the patient upon receipt of our statement.

AUTO ACCIDENT/LIABILITY

Insurance Company _____

Address _____

Claim Number _____

Date of Accident _____

*Being involved in a motor vehicle accident is certainly unfortunate; however, we do not bill your attorney, wait for settlements or accept letters of protection. Billing the "other party's" insurance is an option. However, if they do not pay upon our presentation of a claim, we must ask that you pay, when you receive our statement.

AUTHORIZATION

I authorize my insurer to pay any benefits for physical therapy services to Spine & Sport. I understand that anything not covered by my insurance is fully my responsibility. I hereby authorize Spine & Sport through its appropriate personnel to perform or have performed on me, or the patient named below, appropriate assessment and treatment procedures relating to my diagnosis. I further authorize Spine & Sport to release to appropriate agencies any information acquired in the course of my examination/treatment and permit a photographic or other facsimile of this authorization to be used in place of the original assignment. I have reviewed and understand the notice of privacy practices. A copy of this authorization will be provided upon request.

Patient's (parent/guardian if minor) Signature: _____

Guardian Relationship: _____

Please PRINT name: _____ Date: _____