

Spine & Sport

PHYSICAL THERAPY

PATIENT EXPRESS REGISTRATION

Today's Date: ___ / ___ / ___

Your Full Name _____ Date of Birth _____ Gender _____ M _____ F

Social Security Number _____ Marital Status _____ Single _____ Married

Home Address _____

Home Phone _____ Cell Phone _____

Email Address _____

Emergency Contact Person _____ Phone _____

My condition is related to: _____ Work _____ Auto Accident (State _____) _____ Other

Occupation _____

Employer Name _____

Employer Ph # _____

Family MD _____

Family MD Ph # _____

How did you hear about us? _____

Why did you choose this clinic? _____

Payment Info (check only one box)

- I am paying out-of-pocket (cash) for services.
- I have insurance and would like you to deal directly with them. I will assign my benefits over to you. I understand that I am responsible for any deductible, co-payment or coinsurance associated with my insurance plan. I also understand that my insurance plan may not cover all services received in Physical Therapy and that I am responsible for any non-covered expenses.
- I was injured on the job and my employer will be paying the bills.

The adjuster's name is: _____ Ph # _____

Important Info

We are very committed to you and your goals. We will reserve appointment times for you that allow you the appropriate amount of therapist time for your needs. If you cannot keep your appointment, please call with 24 hours notice so that someone else might benefit from that time. Failure to provide 24 hours notice will result in a fee to you. Nothing will be charged unless you cancel with less than a 24-hour advance notice (\$10 fee) or fail to show (\$25 fee).

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring MD, and/or other third party payer.

Patient Signature Required _____ Date _____