S.P.O.R.T. PHYSICAL THERAPY
PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME: _____ **FIRST NAME:** _____ **MI:** _____

Date of Birth: _____ **SSN:** _____ **Gender:** ☐ male ☐ female

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (___)_____ **Cell Phone:** (___)_____ **Work Phone:** (___)_____

Marital Status (circle): **Married** **Spouse's Name:** _____ **Single** **Divorced** **Widowed** **Separated** **Other**

Employer: _____ **Occupation:** _____

Email Address: _____

Emergency Contact Name: _____ **Relationship:** _____

Address: _____ **Phone Number:** (___)_____

PREFERRED APPOINTMENT REMINDER METHOD:

☐ **Text Message** ☐ **Email** ☐ **Phone Call** **Please specify (home, cell, work, or other):** _____

INSURANCE / GUARANTOR INFORMATION

Have you verified your therapy benefits with your insurance? ☐ **No** ☐ **Yes**

Have you had physical therapy this calendar year? ☐ **No** ☐ **Yes**
If yes, how many treatments have you received this year? _____

(Complete insurance information only if you do not provide us a copy of your card)

Primary Insurance: _____ **Policy Number:** _____

Policyholder: _____ **Date of Birth:** _____ **SSN:** _____

Secondary Insurance: _____ **Policy Number:** _____

Policyholder: _____ **Date of Birth:** _____ **SSN:** _____

Work-Related Injury: ☐ **No** ☐ **Yes** **If Yes, Date of Injury:** _____

Industrial Insurance Company: _____ **Claim Number:** _____

Employer: _____

Auto Accident Injury: ☐ **No** ☐ **Yes** **If Yes, Date of Injury:** _____

Responsible Party's Insurance*: _____ **Claim Number:** _____

Policyholder Name: _____

(*SPORT Physical Therapy does not bill third-party payers)

Patient Name: _____ **Date of Birth:** _____

If patient is under the age of 18, please complete:

Guarantor Name: _____ **Date of Birth:** _____ **SSN:** _____

Relationship to Patient: _____ **Phone Number:** _____

Address (if different than patient): _____

Employer Name: _____ **Work Phone:** (___)_____

REFERRAL INFORMATION

How did you hear about SPORT Physical Therapy: ☐ **Physician** ☐ **Friend/Family** ☐ **Internet** ☐ **Other**

Referring Doctor: _____ **Primary Care Physician:** _____

Diagnosis/Chief Complaint(s): _____

Date of Injury/Onset: _____ **Did You Have Surgery?** ☐ **No** ☐ **Yes** **If Yes, when?** _____

ASSIGNMENT OF BENEFITS / SIGNATURE ON FILE

I certify that all information provided above is true to the best of my knowledge. I understand that if any of the above information changes, it is my responsibility to inform SPORT Physical Therapy Clinic of these changes.

I, the undersigned, consent to the use of Protected Health Information (PHI) for treatment and payment of the above-named person. I authorize SPORT PHYSICAL THERAPY CLINIC to bill my insurance and assign directly to SPORT PHYSICAL THERAPY CLINIC all medical benefits/payments, if any, otherwise payable to me for services and supplies rendered. I understand that SPORT PHYSICAL THERAPY CLINIC will share patient PHI according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices. I hereby authorize SPORT PHYSICAL THERAPY CLINIC to release all information necessary to secure payment of benefits to my insurance company. I authorize the use of this signature on all insurance submissions. This authorization is in effect until I choose to revoke it. I acknowledge and understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I acknowledge and understand that all charges remaining after insurance reimbursement are my financial responsibility.

_____ _____

PATIENT/GUARDIAN/REPRESENTATIVE SIGNATURE **DATE**