

## Specialty Physical Therapy Registration Form

Authorization # \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_\_ Sex: M F

Physical address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone h: \_\_\_\_\_ w: \_\_\_\_\_ cell: \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact person \_\_\_\_\_ Ph.# \_\_\_\_\_

### PRIMARY INSURANCE:

NAME OF INSURANCE COMPANY \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Insured SS# \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group# (IF ANY) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_\_

### SECONDARY/ SUPPLEMENTAL INSURANCE -

NAME OF INSURANCE COMPANY \_\_\_\_\_

Name of Insured \_\_\_\_\_ Insured SS# \_\_\_\_\_

Policy ID # \_\_\_\_\_ Group # (if any) \_\_\_\_\_

Relationship to insured \_\_\_\_\_ DOB \_\_\_\_\_

### PHYSICIAN INFORMATION

Physician :( first) \_\_\_\_\_ (last) \_\_\_\_\_ UPIN # \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ NPI# \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Last physician visit \_\_\_\_\_

### **Financial Responsibility**

I acknowledge and accept full and complete responsibility for payment of all services rendered to me by Specialty Physical Therapy and /or her assignees. I agree to allow Specialty Physical Therapy to bill on my behalf and to accept assignment for the insurance portion allowable and further **agree to pay all deductibles and co-payments not paid by my insurer.** I authorize the use of any photographs, slides, or video tapes of me for educational purposes. I further authorize release of any/all medical records Specialty Physical Therapy may deem necessary. I agree to pay for any bandages, probes, & compression garments that my insurance does not pay. I understand that my protected health information will be used only for treatment, payment, or continuing healthcare operations. Any non-TPO disclosure will only occur after giving my specific consent. I also give my consent to Specialty Physical Therapy to discuss my case with appropriate medical professionals. Specialty Physical Therapy's policy and procedure re: security and privacy are available in the office.

I have been advised that the estimated cost per session is \$ \_\_\_\_\_.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print \_\_\_\_\_

**\*\*\* Please remind patient to bring calendar, drug list, med cards & PHX**