PT² Physical & Sports Therapy with a Personal Touch

New Patient Registration

Please Print Clearly

Date:		
Last:	First:	MI:
Address:		
City:	State:	Zip:
Home Phone:	Work:	Cell:
SSN:	DOB:	Sex: M / F
Email:	Status: Married / Single / Other	

Emergency Contact:	Phone:
Referring Physician:	

May we thank someone other than your Doctor for your referral?_____

Employer: _____ Employment: Full / Part-Time / Not Working / Retired / Student

Injury Type: Auto / Work / Other: _____
Lawyer Involved: Yes / No Attorney's Name:_____

Private Insurance Information

Name of Insured:
Insured's Address if different:
Insured's SSN:
Insured's Date of Birth:
Insured's Employer:
Patient's relationship to the Insured Party: Self : ____ Spouse: ____Child: ____ Other: ____ Explain:

Social Security Number: Is required if we are billing your insurance. If you choose NOT to provide your SSN, full payment will be required at the time of service.

Release of Information:

I give permission to PT² Physical & Sports Therapy to release information to my insurance company, attorney, assignees and/or Beneficiaries. I understand that PT² Physical & Sports Therapy may use or disclose my personal health information for the purposes of: carrying out treatment, obtaining payment, evaluating quality of services provided as well as any administrative operations associated with treatment or payment.

Assignment of Benefits:

I authorize payment directly to PT² Physical & Sports Therapy for services I receive.

Consent of Treatment:

I give my legal consent for PT² Physical & Sports Therapy Inc. to furnish medical care and treatment considered to be necessary for my or the patient's diagnosed condition.

Cancellation Policy:

I understand that I must give a **24 Hour Notice for Cancellations** and failure to do so will result in a $50.00 fee.

Financial Responsibility:

As a courtesy to you, we will bill your primary insurance directly. We do not receive specific information on amounts of coverage or guarantee of payment from your insurance carrier. Ultimately, **YOU ARE RESPONSIBLE** to pay for all services rendered to you regardless of what we may have been told by your insurance carrier.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES:

Patient/Guardian Signature: _____Date: _____