Patient Registration and Consent Form

Patient Name: ______________________________ **Date:**______________

Legal Name (if different): ___________________________ Date of Birth: _____________ SSN: _____________________
(required for billing procedures)

Mailing Address: ____________________________ City:____________________ State: _______ Zip: _______________

Physical Address: ___________________________ City: ___________________ State: _______ Zip: _______________

Phone (Home):______________________________ Phone (Mobile): _______________________________

Email: _____________________________________ Marital Status: ________________________________
(for office purposes only)

In case of emergency, contact: __________________________ Relationship: _______________ Phone: _____________

How would you prefer your automated appointment reminder? Call or Text _________________

Referring Physician: ______________________________ Primary Care Physician: _____________________________

Diagnosis / Surgery: ______________________________ Date of onset/ Surgery: ______________________________

HOW DO YOU WISH TO PAY FOR SERVICES: SELF PAY INSURANCE WORKER'S COMPENSATION

Do you have Medicare? YES / NO

Are you currently receiving Hospice Care, Home Health, or other PT services? YES/ NO

Are you currently working with an attorney in association with this injury or condition? YES/ NO

INSURANCE FILING:

Primary Insurance: ___________________________________ Policy # ___________________________________

Policy holder's name: ___________________________________ Policy holder's date of birth: __________________

Relationship to policy holder? ___________________________________

Secondary Insurance: ___________________________________ Policy # ___________________________________

Policy holder's name: ___________________________________ Policy holder's date of birth: _____________________

Relationship to policy holder? ___________________________________

WORKERS COMPENSATION FILING:

Worker's Compensation Company:___________________________Claim Number: _______________________________

Adjuster or Contact Person: ________________________________ Phone Number: _____________________________

Employer: _____________________________________ Job Title: ____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim for communications with my referring medical providers. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Elkins Physical Therapy Service, Inc. regardless of participation in or out-of network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient Signature: **Date:**

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient Signature: **Date:**