

P.T. _____

Rx Date _____

Diagnosis: 1) _____

2) _____

3) _____

Date of Injury: _____

Insurance Verified _____
Authorization # _____



PATIENT REGISTRATION

FOR OFFICE USE ONLY

Patient #:

Is Patient (circle one):

Left-Handed

Right-Handed

Patient's Name _____

Sex (circle one):

Male

Female

(LAST)

(FIRST)

(MI)

If none, Mother's S.S. #: _____

Birth Date: _____ Age: _____

Patient's Social Security #: _____ Father's S.S.# _____

Guarantor's Name _____

Patient's Address

Street _____

City _____ State _____ Zip _____

Guarantor's Address

Street _____

(If different from patient)

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Referring Dr. _____

INSURANCE

Marital Status (circle one) 1. Married 2. Single 3. Divorced 4. Widow(er) 5. Separated

How did you hear about our practice? _____

(Circle one): Work Related Auto Accident Other: _____

Patient's Employer Name: _____ Occupation: _____

Closest Relative or Friend Other Than Husband or Wife (Not in Home)

Name _____ Telephone _____

Address _____

*****PLEASE READ THE INFORMATION ON THE BACK OF THIS PAGE AND SIGN*****

**AUTHORIZATION TO RELEASE INFORMATION
AND PAY BENEFITS DIRECTLY TO PHYSICAL THERAPIST**

I hereby consent to treatment by Atlantic Physical Therapy, PC (APT) physical therapists, their associates and/or assistants and I accept responsibility for fees charged for these physical therapy services. I understand that treatment may include therapeutic modalities (such as moist heat packs, cold packs, ultrasound, and electrical stimulation), joint mobilization, therapeutic exercise, and/or other such procedures as are deemed necessary.

I authorize direct payment to the APT physical therapists for amounts payable by my present insurance policy or any future policies that I obtain. I will advise APT of any changes to my insurance coverage.

I authorize the release of any Protected Health Information (PHI) necessary for filing insurance claims. I hereby further understand Atlantic Physical Therapy is authorized by me to use or disclose my PHI for the purpose of my treatment, payment or health care operations. I also understand that I retain the right to revoke this authorization in writing at a later date. In the event disclosure of PHI is necessary, for reasons other than those previously listed, a separate form will be provided to you for your authorized signature.

I understand that insurance is filed as a courtesy, and I agree to fulfill my financial responsibilities as delineated by my policy. I accept responsibility for legal and collection agency fees if I allow my account to become delinquent.

If health care workers are inadvertently exposed to my blood or bodily fluids, I agree to have my blood tested for infectious diseases, which might be transmitted in such an exposure, including HIV and hepatitis.

I have received the Atlantic Physical Therapy Notice of Privacy Practices and I have been provided an opportunity to review it.

Signed: _____ Date: _____
Patient or Responsible Party

Witness: _____