PT _____
Date of Rx _____
Dx _____

Insurance Verified_____
_____

PATIENT REGISTRATION

Account #

Patient's Name: (LAST, FIRST MI) _____

Patient's Address: _____

City: _____ State: _____ Zip: _____

Patient is: (circle one) Left-Handed Right-Handed **Sex (circle one):** Male Female

Birth Date: _____ **Age:** _____ **Patient's Social Security #:** _____

If Patient is a minor, either Father's S.S. #: _____ or Mother's S. S. #: _____

Home Phone: _____ **Work Phone:** _____ **Referring Doctor:**_____

Cell Phone: _____ **E-mail:** _____

Marital Status (circle one): Married Single Divorced Widow(er) Separated

How did you hear about our practice? _____

Was this an injury? Sports Related _____ Work Related _____ Auto Accident _____ Other: _____

Patient's Employer Name: _____ **Occupation:** _____

Responsible Party (if different from patient):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact:

Name: _____ Phone #: _____

Address: _____

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

OFFICE USE ONLY – INSURANCE INFORMATION

AUTHORIZATION TO RELEASE INFORMATION
AND TO PAY BENEFITS TO PHYSICAL THERAPIST

I HEREBY CONSENT TO TREATMENT by Atlantic Physical Therapy, P.C. (APT) physical therapists, their associates and/or assistants and accept responsibility for fees for such physical therapy services. I understand that treatment may include therapeutic exercise, therapeutic modalities (such as ultrasound, moist heat, cold packs), joint mobilizations, and/or such other procedures as deemed necessary.

I hereby authorize the release of any information necessary for filing my insurance claims and direct payment to the APT physical therapists for any amounts due under my present policy(ies) or any policy that I may at a later date ask to be filed. This authorization is valid for current and subsequent treatment unless I submit a written revocation. A photo static copy of this authorization shall be considered as effective and valid as the original. I will advise APT of any changes in insurance coverage.

Atlantic Physical Therapy will assist in the filling of insurance claims for physical therapy benefits including obtaining necessary authorization and documentation of the physical therapy services provided. I understand that I will be responsible for those charges not covered by my insurance company including deductibles, co-insurance, and/or co-payments. These fees will be due at the time services are rendered unless other arrangements have been made in writing with an authorized representative of Atlantic Physical Therapy.

I will be responsible for the charges that remain after my insurance company has paid the benefit under my policy. Atlantic Physical Therapy will allow 60 days for insurance claims to be processed. After 60 days, I will assume responsibility for the remaining balance unless Atlantic Physical Therapy has been given written notification by my insurance company that my claim is still actively being processed for payment.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Signed: _____ Date: _____
(Patient or Responsible Party)

Witnessed:_____