

ProSport Physical Therapy I

Patient Registration Form

Date: _____

Primary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>				Secondary Insurance: Medicare <input type="checkbox"/> Group Health <input type="checkbox"/> Workers Comp <input type="checkbox"/> Lien <input type="checkbox"/> Other <input type="checkbox"/>										
<input type="checkbox"/> New Patient			<input type="checkbox"/> Re-Start			<input type="checkbox"/> New Diagnosis			<input type="checkbox"/> New Insurance			PTPN <input type="checkbox"/> Yes <input type="checkbox"/> No		
Patient #		Title		Patient Name (Last, First, Middle Initial)										
Address						City/State/Zip								
Home Phone ()				Work Phone ()				Email Address						
Social Security #		DOB		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License #		Financial Class						
Referring Physician				UPIN		Referring Physician Phone#			Treating Therapist					
Patient Status <input type="checkbox"/> Active <input type="checkbox"/> SFA		Primary location CLINIC		Marital Status		Student		Employment Status						
Occupation				Employer				Employer Phone #						
Address						City/State/Zip								

Emergency Contact (Name)				Home Phone ()				Work Phone ()			
Address				City/State/Zip				Relationship to Patient			

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)						Relationship to Patient					
Address						City/State/Zip					
Home Phone ()				Work Phone ()				Email Address			
Social Security #		DOB		Gender <input type="checkbox"/> M <input type="checkbox"/> F		Driver's License #					

Injury Information

Is condition surgery related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Surgery		Surgical Procedure					
Is condition accident related? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was an automobile involved? <input type="checkbox"/> Yes <input type="checkbox"/> No				Date of Accident			
Describe Accident									
Were you injured on the job? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Injury				Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> No			
Name of employer at time of accident				City, State, Zip Code					
Describe Injury									
Is litigation involved? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Attorney				Phone # ()			

-Office Use Only-

Diagnosis:						ICD-9 Code:					
Diagnosis:						ICD-9 Code:					
Diagnosis:						ICD-9 Code:					

Insurance Information

Were benefits and authorization verified? Yes No

Primary Insurance		In- network <input type="checkbox"/>	Out-of-network <input type="checkbox"/>	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No		Visits per Year
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship to Patient	
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty \$	Visits Remaining	
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()			
Benefits Verified By		Date	Spoke to		Ins. Customer Service Phone # ()	

Secondary Insurance		In- network <input type="checkbox"/>	Out-of-network <input type="checkbox"/>			
Claims Mailing Address			City, State, Zip Code			
Subscriber Name		Date of Birth	Sex <input type="checkbox"/> M <input type="checkbox"/> F		Relationship to Patient	
ID Card #(including alpha prefix)		Group #		Authorization #		
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay \$	Pre-Certification <input type="checkbox"/> Yes <input type="checkbox"/> No	Visits per Year
Deductible Start Amount \$	Deductible Remaining Amount \$		Pre-Certification Phone # ()			
Benefits Verified By		Date	Spoke to		Ins. Customer Service Phone # ()	

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by ProSport Physical Therapy I and assigns to ProSport Physical Therapy I any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes ProSport Physical Therapy I to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or ProSport Physical Therapy I for payment of charges to the patient.
4. ProSport Physical Therapy I reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for ProSport Physical Therapy I.

Patient Signature:	Date:
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<i>CPM Office Use Only:</i>	Entered by:	Date:
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