Patient Registration and Consent

Full Name:____ Date of Birth:______________ SSN:___________________

Mailing Address:______________________________ City:__________________ State:__________ Zip:____________

Physical Address: ______________________________ City:__________________ State:__________ Zip:____________

Phone (Home): __________________________ (Work): _______________________ (Cell):______________________

Email: ____ Marital Status: ________________
(for office contact purposes only)

In case of emergency, contact: _______________________ Relationship: _______________ Phone: _________________

How do you prefer your automated appointment reminder? Call or Text ___________________________________

Employer: ____________________________________ Occupation: ________________________________

Contact person: __________________________________ Phone: ____________________________________

Has a claim been filed to the workers compensation carrier? Yes / No

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Referring Physician:_________________________________ Primary Care Physician: ____________________________

Type of Injury/ Surgery: ____ Date of Onset/ Surgery:_________________

HOW DO YOU WISH TO PAY FOR SERVICES: INSURANCE SELF PAY LAWYER WORK COMP

DO YOU HAVE MEDICARE? YES/ NO IF YES ARE YOU UNDER CARE OF HOSPICE, HOME HEALTH, OR OTHER PT? YES/NO

Primary Insurance:____ Phone: ________________________________

Policy #: __________________________ Group #: _______________ Benefit Period: _______________ to _______________

Policy holder's name: ________________________________ Date of Birth: ______________Employer: _______________________

What is your relationship to policyholder? Self Spouse Child Other

Deductible $____________ How Much is Met $____________ Out of Pocket $____________ How Much is Met $____________

Copay/Co-Insurance: _______________ Max visit limit: _____________ Cap: _____________

Secondary Insurance:____ Phone: ___________________________________

Policy #: __________________________ Group #: _______________ Benefit Period: _______________ to _______________

Policy holder's name: ________________________________ Date of Birth: ______________Employer: _______________________

What is your relationship to policyholder? Self Spouse Child Other

Deductible $____________ How Much is Met $____________ Out of Pocket $____________ How Much is Met $____________

Copay/Co-Insurance: _______________ Max visit limit: _____________ Cap: _____________

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. 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/Parent/Guardian 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/Parent/Guardian Signature:____ **Date:**_______________