

Amity Physical Therapy LLC

PATIENT REGISTRATION

Patient: _____ DOB: _____ Soc Sec # _____

Address: _____ City _____ Zip _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ EMAIL: _____

Patient's Employer: _____

Marital Status: Married: _____ Divorced: _____ Single: _____ Widowed: _____

Person to Contact in case of Emergency: _____ Phone: _____

Person to Bill: _____ Address: _____

Injured body part _____

Referring Physician: _____

How Did You Hear About Us: _____

ARE YOU CURRENTLY RECEIVING HOME CARE (MEDICARE ONLY) _____

INFORMATION

Were you involved in an accident? ___ If yes, when? _____ Auto or at Work? : _____

Work Comp/Auto Insurance: _____ Contact Name: _____

Date of injury: _____ State: _____ Phone#: _____

Policy/Claim # _____ Employer: _____

Attorney Name/Address/Phone #

Primary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

Subscriber SS#: _____ Subscriber DOB: _____

ID: Number: _____ Group # _____

Phone # _____

Secondary Insurance Name: _____

Subscriber Name: _____ Relationship to Insured: _____

ID: Number: _____ Group# _____

Phone# _____

Amity Physical Therapy LLC

INSURANCE INFORMATION AND CONSENT

I hereby authorize **Amity Physical Therapy LLC** to furnish information concerning my illness and treatments to insurance carriers and any other payor to process and collect this claim. I hereby assign to **Amity Physical Therapy LLC** all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also agree to receive treatment at **Amity Physical Therapy LLC** today.

CONSENT

In order to improve my physical condition in regards to pain, range of motion, strength, or another type of physical impairment, I consent to enter the Amity Physical Therapy program for evaluation and treatment.

RISKS

I am aware that there are certain risks involved with a physical therapy program. Every effort is made to minimize my risk by continuous assessments of my condition throughout my therapy.

RESONSIBILITIES

- I will inform my therapist **of any** changes in my medical condition, or medications, as they may necessitate change in my therapy program.
- I will stop any procedure or activity and inform my therapist of any symptoms of pain, fatigue, shortness of breath, dizziness or nausea that may develop during my treatment.
- As a courtesy, Amity Physical Therapy will verify your insurance coverage for you. We will notify you of your co-payment, co-insurance or deductible amount. This is not a guarantee of payment by your insurance company and any discrepancy in coverage is between you and your insurance company.

I authorize the release of any medical or other information necessary to process this claim. I also request payment of governmental benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNATURE _____

DATE _____

I have reviewed the Notice of Use and Disclosure of Protected Information. I understand this notice and have had the opportunity to ask any questions regarding matters of concern.

I have read, understand and agree to the above listed categories

SIGNATURE _____

DATE _____

This notice was effective beginning April 14, 2003