



Patient Registration Form

Personal Information

Name:	Name you prefer:	
Home Address:	Apt #	
City:	State:	Zip Code:
Mailing Address:		
City:	State:	Zip Code:
Injury/ Diagnosis:	Home Phone:	
Date of Injury/Onset of symptoms:	Work Phone:	
Date of Birth:	Age:	Cell Phone:
Email Address:		
Emergency Contact:	Emergency Contact Phone #:	
How did you hear about us?:		

Referring Physician Name:	Phone #:
City, State:	
Primary Care Physician Name:	Phone #:
City, State:	
Employer Name:	Occupation:
Address:	City, State:
Social Security Number (For Insurance Benefit Verification):	

Primary Insurance Information

Is this an auto accident?:	Yes	No	Is this a worker's comp case?:	Yes	No
If "Yes", list claim # and adjuster contact information:					
Health Insurance Company Name:					
Subscriber's Name:			Subscriber's Date of Birth:		
Relationship to the Subscriber:					
Subscriber's Address and Phone # if different from patient:					
Address:					
City, State		Zip		Phone#	

Secondary Health Insurance Information

Health Insurance Company Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____

Relationship to the Subscriber: _____

Subscriber's Address and Phone # if different from patient: _____

Address: _____

City, State _____

Zip _____

Phone# _____

Consent to Treatment

I hereby authorize the professional staff at Competitive Edge Physical Therapy to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

Patient Signature

Date

Patient Printed Name

Parent or Guardian Signature (if under 18)

Date

Parent or Guardian Printed Name

Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: **Competitive Edge Physical Therapy** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy. I understand that **Competitive Edge Physical Therapy** is compliant with HIPAA will protect my *Protected Health Information (PHI)* and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines. The authorization is in effect until 90 days from the date the last bill is collected. A photocopy of this Assignment shall be considered effective and valid as the original.

If there is anyone you would like authorize the disclosure of your Protected Health Information, medical or billing, you may specifically name the party below and initial next to what information you would like to disclose: _____

Info related to diagnosis and physical therapy treatment ONLY _____

Medical Billing Info ONLY _____

My entire medical record _____

Patient Name (Printed)

Date

Patient Signature

Parent or Guardian (Printed)

Relationship

Parent or Guardian Signature

Staff Witness Signature

Date