REBECCA STREET PHYSICAL THERAPY

PATIENT REGISTRATION (Please print)

Patient Name________________________________ Home Ph:_____________________ Cell/Msg Ph________________

Address____________________________________ Date of Birth:__________________ SS#: ______________________

City, State, Zip:____ DL#: ______________________

Are you:

❑ Married	❑ Single	❑ Separated
❑ Divorced	❑ Widowed	❑ Student (FT)

Emergency Contact?_________________________________

Ph: ____

Spouse:________________________ Spouse Employer: __________________________ Spouse Ph:________________

EMPLOYMENT INFORMATION:

Employer ____ Are you retired?:_____ When:_____________

Employer Address:____ Occupation: __________________________

City, State, Zip:____

May we contact you at work?__________Work Ph:________________________

❖ **PRIVATE/GROUP INSURANCE:**

Insurance Company Name	Policy Holder (Subscriber)	Policy ID and Group #
1.		
2.		
3.		

❖ **Will this claim be covered under Worker's Compensation: Yes ________ No________**

Insurance Company (not the employer)_________________________________ Policy/claim #_________________________

Address to send claims:____ Date of injury _________________________

City, State, Zip:____ State where loss occurred:_______________

Adjuster's Name:________________________ Phone:____________________ Fax:______________________________________

❖ **If physical therapy is to be covered by your auto insurance, please provide the following information:**

Auto Insurance Company (not the agent)_________________________________ Policy/claim #_________________________

Address to send claims:____ Date of Loss __________________________

City, State, Zip:____ State where loss occurred:_______________

Adjuster's Name:________________________ Phone:____________________ Fax:______________________________________

(CONTINUED ON BACK) ➲

RESPONSIBLE PARTY: (Please complete the section below if someone other than the patient or spouse is responsible for the payment of services)

Name	Relationship to patient	Home Phone	Bus Phone

Address	City	State	ZIP	SSN#

Employer	Employer's Address	City	State	ZIP

CONDITIONS OF REGISTRATION AND FINANCIAL AGREEMENT

Medical Consent to Treatment: The patient is under the care and supervision of his/her attending physician and it is the responsibility of the rehab staff to carry out the instructions of such physician. The undersigned consents to non-emergent outpatient treatment and services rendered the patient under the general and special instructions of the physician.
Financial Agreement: The signor agrees, whether he/she signs as agent or as patient, that in consideration of services to be rendered to the patient, he/she is individually obligated to pay the clinic's bills promptly as bills are presented. The amount due from the patient/guarantor will be the clinic's charges, as modified by any applicable agreement between the clinic and the patient's health care insurance/benefits provider. All insurance co-payments deductibles and non-covered charges are due from the patient/guarantor at the time of billing by the clinic. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses. Accounts remaining open beyond 60 days without payment may be charged 1.5% interest per month on the unpaid balance which is the responsibility of the patient or responsible party, not the insurance carrier.
Medicare Assignment: I certify that the information given by me in applying for payment from any third party payer, including payment under Title XVIII of the Social Security Act, is correct. I request that payment of authorized benefits be made in my behalf, and I hereby authorize the Social Security Administration Office of the Department of Health and Human Services to release information regarding my eligibility for coverage under Medicare Part B, including but not limited to the effective date of such coverage. I also authorize the clinic and my therapist(s) to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim.
Assignment of Insurance Benefits: The signor authorizes, whether he/she signs as agent or patient, direct payment to the clinic of any health care benefits otherwise payable to the undersigned or the patient for this course of treatment. It is agreed that payment to the clinic and therapist(s), pursuant to this authorization, by a third party payer shall discharge said payer of any and all obligations under a policy to the extent of such payment. It is understood by the signor that he/she is financially responsible for all charges not covered by the patient's health care insurance/benefits provider.

I authorize Rebecca Street Physical Therapy to release, by mail or electronic transmission, my medical records to my physician and/or my health insurance company, if requested, for the purpose of billing and payment of the bill. My consent may be revoked at any time. The only exception is when the information has already been released as instructed in the consent. If not previously revoked, this consent will terminate six months after the date of my signing this consent. A photocopy or a faxed copy of the release may be used in place of the original.

The signor certifies that he/she has read the foregoing and is the patient or is authorized by the patient's agent to execute the above and accept its terms.

Signature

Date

Parent or legal guardian signature if applicable