



PATIENT REGISTRATION FORM

Primary Language Spoken: _____ Today's Date: _____

Patient Name _____

Spouse/Partner: _____
Last (if different) First MI

Emergency Contact: _____
Last First Relationship Emergency Contact Phone

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Home Address: _____ City _____ State _____ Zip _____

Mailing Address *(if different from above)* _____

Birthdate: _____ Sex: M / F _____

How were you referred to this office? _____

Primary Insurance: _____ Physician: _____

Group #: _____ ID _____ Employer: _____

Subscriber Name: _____ Patient Relationship: _____

Secondary Insurance: *(if applicable)* _____

Group #: _____ ID _____ Employer: _____

Subscriber Name: _____ Patient Relationship: _____

TREATMENT AUTHORIZATION AND FINANCIAL AGREEMENT: I authorize treatment of patient named above and agree to pay all charges at the time services are rendered unless other arrangements have been agreed upon in advance. If payment of my account is over 60 days late, or it goes to collection, all fees, including collection fees, attorney fees and finance charges (18% APR) will be my responsibility. I hereby authorize the release of any information necessary for payment of charges incurred.

Signature: _____ Date: _____ Relationship: _____

If the PATIENT is a MINOR, I authorize medical care to be provided if I am not present.

Signature: _____ Date: _____ Relationship: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and request my insurance company to pay directly to Core Physical Therapy the amount(s) due on my claim for services provided to me or my dependents. I further agree that should the amount be insufficient to cover the entire medical/rehabilitation expense, I will be responsible for payment of the difference, and if the nature of the disability is such that it is not covered by the policy, I will be responsible to Core Physical Therapy for payment of the entire bill.

Signature: _____ Date: _____ Relationship: _____

(In order to reduce paper waste and for your convenience, we are collecting your signature on this completed form ONCE per calendar year. In the event that any of the above information has changed, we will need to collect an updated form and signature from you. Please note that your signed agreement will be in effect for all subsequent physical therapy visits in the same calendar year.)