HEALTHY FOCUS Physical Therapy

NEW PATIENT REGISTRATION

Last Name____________________First_______________Initial___Birthdate___________

Address______________________________City_______________State____Zip________

Marital Status: Single( ) Married( ) Other( ) Home Tele_____________Cell_____________

Employed( ) Student( ) Employer Name/School____________________________________

Title/Position_______________________________Work Tele_______________________

Referring Physician Name______________________________Tele___________________

Address____

Primary Insurance Company____

Secondary Insurance Company____

In case of Emergency call: Last Name______________________First________________

Relationship______________________________________

Tele___________________________

Guarantor other than insured: Last Name_____________________First______________

Relationship____________________Tele_______________

How did you hear about our clinic? __Physician __Internet __Insurance __Friend/Family __Phone Book __Other

Email Address:____

I would like to receive health education information in the future YES ( ) NO ( )

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By initialing the following statements I am acknowledging that I have fully read and understand each statement.

____I understand that it is my responsibility to completely understand my physical therapy policy benefits and limitations and that I am financially responsible for all charges that are not covered by my insurance company.

____I assign all medical benefits to Healthy Focus Physical Therapy. I authorize my insurance company to pay my benefits directly to Healthy Focus Physical Therapy.

____I authorize Healthy Focus Physical Therapy to release medical information that may be necessary in order to process my insurance claims.

____I do consent to treatment by the authorized personnel of Healthy Focus Physical Therapy as may be dictated by prudent medical practice because of my illness, injury or condition. This consent is intended as a waiver of liability of such treatment except for acts of negligence.

____I understand that interest may be charged at a rate of 1% per month (12% annually) for unpaid. balances over 30 days old.

____I understand that I am responsible to pay $50 for no show appointments or cancellations with less than 24 hours notice. Failure to show for 2 consecutive visits may result in discharge from physical therapy.

____I have read a Notice of Patient Information Practices (HIPAA) from Healthy Focus Physical Therapy. I realize that if at any time I have questions regarding HIPAA I may contact the office.

Signature____Date_______________