Howard County Physical Therapy & Sports Rehabilitation

PATIENT REGISTRATION TODAY'S DATE: ______________________

PATIENT'S NAME: ____ SEX: FEMALE / MALE

ADDRESS: ____

CITY: ____ STATE: ______________ ZIP: __________________

HOME PHONE: __________________________________ WORK PHONE: ______________________________

CELL PHONE: ____________________________ E-MAIL ADDRESS: ________________________________

DATE OF BIRTH: ____________________ AGE: _________________ SOC.SEC.#: ________________________

MARITAL STATUS: (CIRCLE ONE) SINGLE / MARRIED / SEPARATED / DIVORCED / WIDOWED

OCCUPATION: ________________________________ EMPLOYER: __________________________________

WHO REFERRED YOU TO THIS FACILITY? (CIRCLE ONE): SELF PHYSICIAN FRIEND OTHER:______________

REFERRING PHYSICIAN: _________________________ PRIMARY CARE PHYSICIAN: ____________________

PROBLEM THAT BRINGS YOU HERE: ____

____

DATE OF ONSET/SYMPTOMS/SURGERY: ____

TESTS OR PROCEDURES PERFORMED (X-RAYS, EMG, CT SCAN, ETC.): ___________________________________

SPOUSE'S NAME (OR PARENT'S NAME IF MINOR): ____

SPOUSE/PARENT EMPLOYED BY: _________________________ WORK PHONE #: __________________________

IN CASE OF EMERGENCY, PLEASE CONTACT:

NAME: ______________________________ PHONE #: ____________________ RELATIONSHIP: _______________

PATIENT'S AUTHORIZATION

I give my consent to allow Howard County Physical Therapy & Sports Rehabilitation (HCPT) to evaluate and, if necessary, to treat me. ________ (initial)

I hereby authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to HCPT. I hereby authorize photocopies of this form to be as valid as the original. I authorize the electronic submission of my claims and the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to party who accepts assignment. I authorize payment of medical benefits to HCPT for services provided. _________ (initial)

I hereby acknowledge receipt of the HCPT Notice of Privacy Practices as they relate to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ____________ (initial)

CONTINUED ON BACK

HEALTH INSURANCE (PRIMARY – INSURANCE FILED FIRST):

COMPANY NAME: ________________________POLICY #: _____________________________ GROUP #: _________________

POLICY HOLDER NAME:____ DOB: ___________________________

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

HEALTH INSURANCE (SECONDARY – INSURANCE FILED SECOND):

COMPANY NAME: ________________________POLICY #: _____________________________ GROUP #: _________________

POLICY HOLDER NAME:____ DOB: ___________________________

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT

DO YOU PARTICIPATE IN ANY OF THE FOLLOWING? (circle) HSA HRA FSA SECTION 125 PLAN

IS THIS THE RESULT OF AN AUTO ACCIDENT: YES / NO WORKER'S COMPENSATION: YES / NO OTHER ACCIDENT: YES / NO

IF OTHER, PLEASE EXPLAIN: ____

DATE OF ACCIDENT: ____

IF WORK ACCIDENT, NAME OF EMPLOYER: ____

EMPLOYER'S ADDRESS: ____

IF AUTO ACCIDENT, NAME OF CAR OWNER: ____

INSURANCE COMPANY: ____________________________________ CLAIM NUMBER: ____________________________

ADDRESS: ____ CITY, STATE, ZIP: ____________________________

CLAIM ADJUSTER: ____ PHONE NUMBER: _____________________________

HAVE YOU SUBMITTED ANY CLAIMS TO PIP, INCLUDING LOST WAGES? YES / NO

DOLLAR AMOUNT OF PIP AVAILABLE**: ____

****IF YOU DO NOT KNOW THE AMOUNT OF PIP AVAILABLE, PLEASE CONTACT YOUR INSURANCE COMPANY****

I recognize that it is my responsibility to know and understand my insurance benefits and to follow the guidelines as required by my insurance. I recognize that I am financially responsible for all charges for all medical care and services rendered by HCPT and/or by its staff. All claims are subject to review by my insurance carrier. I am responsible for all charges deemed non-covered and/or not medically necessary by my insurance carrier. I am aware that payments due will be collected at the time of service.

___________________________ ____ ____

Date Patient's/Guardian's Signature [seal] Witness