PHYSICAL THERAPY SOLUTIONS, LLC

NEW PATIENT REGISTRATION

PLEASE COMPLETE ALL APPLICABLE SECTIONS.
FAILURE TO COMPLETE CAN DELAY PAYMENT. PLEASE PRINT CLEARLY

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	SEX

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE

MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )	HAVE YOU BEEN TREATED AT THIS CLINIC BEFORE? IF YES, WHEN?

EMPLOYMENT STATUS EMPLOYED ( ) F/T STUDENT ( ) P/T STUDENT ( ) OTHER ( )	EMPLOYER NAME / SCHOOL NAME	TITLE / POSITION

WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE

PRIMARY CARE PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE

IN CASE OF EMERGENCY CALL

LAST NAME	FIRST	RELATIONSHIP

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE

REASON FOR TODAY'S VISIT

IS THIS INJURY / CONDITION RELATED TO YOUR:		DO YOU HAVE MED PAY COVERAGE? YES ( ) NO ( )	
JOB: YES ( ) NO ( )	CAR: YES ( ) NO ( )	HOME: YES ( ) NO ( )	OTHER ACCIDENT: YES ( ) NO ( )

DATE OF ACCIDENT OR INJURY:	DATE OF ILLNESS (FIRST SYMPTOM)

NAME OF INSURANCE ADJUSTER OR CONTACT:	TELEPHONE

DESCRIBE INJURY / ACCIDENT / ILLNESS:	ATTORNEY NAME: TELEPHONE:

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY

RESPONSIBLE PARTY'S SIGNATURE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	TODAY'S DATE
		/ /	/ /

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER		GROUP NUMBER	
ADDRESS	CITY	STATE	ZIP CODE	PHONE

POLICY HOLDER (if other than patient)	SEX	DATE OF BIRTH
		/ /

SOCIAL SECURITY NUMBER (of policy holder)	PHONE NUMBER (of policy holder)	RELATIONSHIP TO PATIENT

EMPLOYER (of policy holder)

ADDRESS (of policy holder)	CITY	STATE	ZIP CODE	PHONE

PHYSICAL THERAPY SOLUTIONS' PAYMENT POLICY

We are happy to extend our services by filing your primary and secondary insurance for you. Please select from the following payment choices:

_____ Self Pay: Please pay the balance in full at the time of service. In the event that you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection.

_____ Workers' Compensation: We will bill your Workers' Compensation Carrier for your charges. Please note that you will remain financially responsible for any and all charges if your carrier denies coverage or your claim is controverted.

_____ Primary and Secondary Insurance: We will bill your primary and secondary insurance carriers. We assume payment of insurance benefits is not forthcoming on charges older than 45 days. Charges outstanding for more than 45 days from the date of filing will be due in full from you regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been processed by your insurance carrier.

PLEASE BE AWARE THAT WE REQUIRE PAYMENT FOR ALL MONIES DUE THAT YOUR INSURANCE WILL NOT COVER AT THE TIME OF SERVICE.

ALL SUPPLIES ARE PAYABLE AT THE TIME OF SERVICE AND CANNOT BE CHARGED TO YOUR INSURANCE CARRIER. HOWEVER, WE WILL FILE FOR ANY COVERED SUPPLIES ALLOWED BY YOUR INSURANCE CARRIER.

Patients will receive a statement of account via mail every 30 days. Payment of patient due portion is payable within 10 days.

Thank you for allowing us the opportunity to serve you.

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Physical Therapy Solutions in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. A service charge or interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over ninety (90) days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Physical Therapy Solutions as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

AUTHORIZED SIGNATURE	TODAY'S DATE
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