PHYSICAL THERAPY ASSOCIATES

REGISTRATION FORM

DATE:

PATIENT INFORMATION

Name:	**Work Phone Number:**
Address:	**Social Security Number:**
City / State / Zip:	**Birthdate:**
Home Phone Number:	**E-Mail:**
Cell Phone:	**Referring Physician:**
Sex:	**Emergency Contact:**
Status:	**Phone Number of Emergency Contact:**

PATIENT EMPLOYER INFORMATION

Employer Name:	**Date of Injury:**
Address:	**Contact Name:**
City / State / Zip:	**Work Related:**
Occupation:	

PRIMARY INSURANCE INFORMATION

Insurance Carrier:	**Employer of Insured:**
Name of Insured:	**Date of Birth of Insured:**
ID Number:	**Group Number:**

SECONDARY INSURANCE INFORMATION

Insurance Carrier:	Employer of Insured:
Name of Insured:	Date of Birth of Insured:
ID Number:	Group Number:

DUE TO FEDERAL PRIVACY RULES (HIPPA) we cannot speak to anyone other than yourself regarding your treatment or bill without your consent. Please indicate the person(s) that you are authorizing us to release your personal protected health information to:

Person/s: **Relationship To Person/s:**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide in such restrictions.

I authorize my insurer to pay any benefits for services rendered directly to Physical Therapy Associates. I understand that anything not covered by insurance is my full responsibility. I hereby authorize Physical Therapy Associates through it's appropriate personnel to perform on me, or the patient named above, appropriate assessment and treatment procedures relating to my diagnosis.

Initials of Patient / Parent (if minor): **Date:**
Print Name: