

OrthoCare Physical Therapy and Sports Rehabilitation

PATIENT REGISTRATION FORM

Last Name: _____ First Name: _____ Male Female

Date of Birth: _____ Age: _____ Social Security Number: _____ - _____ - _____

Marital Status: Married Divorced Single Widowed Other

MAILING ADDRESS

Street Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

CONTACT INFORMATION

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

Responsible Parent or Guardian if Patient is under 18: _____

Emergency Contact: _____ Phone #: _____ Relation to patient: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Email Address: _____

Primary Insurance Information

****All information pertains to the policyholder****

Insurance Name: _____ ID #: _____

Policy Holder: _____ Relationship to patient: _____

Address: (if different from patient) _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Occupation: _____

Secondary Insurance Information

****All information pertains to the policyholder****

Insurance Name: _____ ID #: _____

Policy Holder: _____ Relationship to patient: _____

Address: (if different from patient) _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ Occupation: _____

Worker's Compensation or No Fault Insurance only

Insurance Company Name/: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Name _____ Phone _____ Fax: _____

WCB: _____ CarrierCase#: _____ Claim/File#: _____

Policy#: _____ Date of Accident _____ Policy Holder: _____

I hereby authorize the release of any medical information necessary to process my insurance claim and request direct payment be made to OrthoCare Physical Therapy and Sports Rehabilitation, PC. I authorize the physical therapists to proceed with my care and I understand I will be responsible for ALL charges not covered by my insurance including co-payments, co insurances and deductibles. Any such payment will be required at the time of services rendered. I also understand that it is my responsibility to obtain all necessary referrals and prescriptions and if said referrals are not obtained, I am responsible for charges not covered under the referral.

Patient (Parent/Guardian) Signature: _____ Date: _____

Financial Policy and Patient Guidelines

1. I understand that my co-pay, co-insurance and/or deductible are due at the time of my visit.
2. I understand that I am responsible for all charges not covered by my insurance and that my account may be placed in collections and that I am responsible for all fees associated with such actions.
3. If a check on my account is returned from the bank, I will incur a \$25.00 service charge.
4. I understand OrthoCare may place a 21% interest rate on all unpaid balances past 90 days.
5. In order to achieve maximum benefit from your rehabilitation program, it is imperative that you attend your physical therapy appointments and follow your home instruction program. (*Compliance to your physical therapy program is the key to your recovery*).
6. I understand I will incur a \$25.00 service charge for any appointments that are missed without a 24-hour notification to the office. This amount will be due at your next visit in addition to your regular co-pay or co-insurance amount. (*It would be fraudulent to submit this fee to your insurance carrier.*)
7. I understand it is my responsibility to schedule appointments at least one to two weeks in advance.
8. OrthoCare Physical Therapy and Sports Rehabilitation, PC reserves the right to reschedule an appointment if I am 15 or more minutes late.
9. If three or more consecutive appointments are missed any time during my treatment, all remaining scheduled appointments may be removed. I will be asked to call and check availability for the day I plan to attend.

Your cooperation is greatly appreciated. We look forward to working with you to obtain optimal outcomes from your rehabilitation program.

I hereby verify that I have read and understand the above financial policies and patient guidelines for the office of OrthoCare Physical Therapy and Sports Rehabilitation, PC.

Signature: _____

Patient Name: _____ Date: _____

By refusing to sign the above document, OrthoCare Physical Therapy and Sports Rehabilitation, PC has the right to refuse to treat the patient unless it is an emergency.

Reason Patient refused to sign: _____

Witness: _____ Date: _____