BETHESDA
PHYSICAL THERAPY

Today's date: ____________________

PATIENT INFORMATION

Patient name: (Last) ______________________________ (First) ______________________________ (MI) ______
Address: ____
Phone (H): ________________________ (W): ________________________ (C): ________________________
Sex: ☐ M ☐ F   Patient's date of birth: ______________________________
Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed
Employed? ☐ Yes ☐ No   Employer/School: ____
Referring physician: ____

PERSON RESPONSIBLE FOR PAYMENT

Guarantor name: (Last) ___________________________ (First) ______________________________ (MI) ____
Address: ____
Phone (H): ________________________ (W): ________________________ (C): ________________________
Sex: ☐ M ☐ F   Guarantor's date of birth: ______________________________
Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

INSURANCE INFORMATION

Primary insurance company: ____________________________ Insured's name: ______________________
Insurance Policy ID#: __________________________________ Insured's date of birth: _________________
Relationship to patient: _________________ Insured's employer: ______________________________________
Secondary insurance company: __________________________ Insurance Policy ID#: ____________________

ADDITIONAL INFORMATION

(Complete only for Worker's compensation or an auto accident.)

☐ Worker's compensation   ☐ Third party liability   ☐ Auto accident

Insurance company: ______________________________ Claim number: ______________________________
Insurance company address: ____
If worker's compensation, name and address of employer at time of injury: ______________________________
____
Contact name: __________________________________ Contact phone: _____________________________

I, ___________________________________ , understand that upon the exhaustion of my PIP/Worker's Compensation benefits, Bethesda Physical Therapy, as a courtesy to me, will bill my primary health insurance. I will, however, be responsible for any documentation necessary for the billing process and for ALL charges not covered thereof.

SIGNATURE: x ____

DATE: ______________________

Registration continued on next page...

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EMERGENCY CONTACT

Name: (Last) ______________________ (First) ______________________ (MI) ____
Relationship to patient: ______________
Address: ____
Phone (H): ______________ (W): ______________ (C): ______________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Bethesda Physical Therapy to furnish information to the insurance carriers listed above concerning my illness and treatments.

SIGNATURE: x ______________________________

DATE: ______________

I hereby assign to Bethesda Physical Therapy all payments for medical services rendered to myself or my dependents until revoked in writing. I understand that I am responsible for any amount not covered by insurance at the time of service. I also understand that I am responsible for collection and legal costs should it be necessary for this account to be turned over to a collection agency.

SIGNATURE: x ______________________________

DATE: ______________

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The "Notice of Privacy Practices" states the manner in which Bethesda Physical Therapy may use or disclose health information for the purposes of treatment, payment for treatment or health care operations in compliance with HIPPA Regulations.

I hereby acknowledge knowledge of the "Notice of Privacy Practices" and consent to the use and disclosure of my personal health information as outlined. I understand that I reserve the right to revoke this consent, in writing, except when disclosures have been made with my prior consent.

____
Name of Patient or Guardian *(Please print)*

x ______________________________
Signature of Patient or Guardian Date

CANCELLATION POLICY

I hereby acknowledge that I may be charged a fee of $25 if I do not give 24-hour notice for cancellation of appointments.

x ______________________________
Signature of Patient or Guardian Date