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PATIENT REGISTRATION AND INFORMATION FORM

Last Name: _____ First Name: _____
 Address: _____ City: _____ State & Zip: _____
 Social Security: _____ Home Phone: _____
 Date of Birth: _____ Marital Status: _____ Sex: _____
 Referral Source: _____ Doctor: _____

Employer: _____
 Work Address: _____
 Work Number: _____

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees Names and Relationships:

* I understand that it is my responsibility to know the limitations and rules of my insurance policy and that if the provider does not receive payment in full from the insurance carrier, I am personally responsible for the remaining balance of the provider's charges.

*I hereby authorize South Bay Sports and Physical Therapy, PC to release any information acquired in the course of my examination or treatment. I hereby authorize photocopies of this information to be valid as original.

*I hereby authorize the insurance carrier to pay directly to South Bay Sports and Physical Therapy, benefits due me out of indemnity under the terms of the policy issued by the carrier.

*I hereby authorize South Bay Sports and Physical Therapy provider to mark the section "AUTHORIZED PERSON'S SIGNATURE" with the notation "SIGNATURE ON FILE".

*I hereby give my consent for South Bay Sports & Physical Therapy, PC to provide physical therapy services.

*I request that payment of authorized Medicare Benefits be made either to me or on my behalf to South Bay Sports and Physical Therapy, PC for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

INSURANCE INFORMATION:

- 1. **Primary** Insurance company: _____
Policy Holder: _____ Phone #: _____
Group #: _____ ID#: _____
Policy holder's D.O.B.: _____
Policy holder's S.S#: _____

- 2. **Secondary** Insurance company: _____
Policy Holder: _____ Phone #: _____
Group #: _____ ID#: _____
Policy holder's D.O.B.: _____
Policy holder's S.S#: _____

WORKERS COMPENSATION INSURANCE:

Carrier: _____
Mailing Address: _____
Phone #: _____
Worker's Compensation Board#: _____
Case #: _____ Date of Accident: _____
Address of Accident: _____
Employer: _____
Address: _____
Are you working? Yes No (Circle one)

NO FAULT INSURANCE:

Carrier: _____
Mailing Address: _____
Phone: _____
Date of Accident: _____ File #: _____
Policy #: _____ Policy Holder: _____
Address: _____
Relationship: _____ Claim Rep: _____

Please Note: Part of your physical therapy treatment may include electric stimulation. For sanitary reasons it may be necessary for you to purchase a set of electrodes. We have them available for purchase at a nominal fee of \$3.00 per set. Your therapist will advise you if it is required for you to make this purchase.

Patient's or Guardian's Signature: _____
Date: _____