

Advanced Physical Therapy and Rehabilitation Center, LLC

Patient Registration Form

FIRST	MIDDLE	LAST	DATE OF INJURY		
HOME ADDRESS		CITY	STATE	ZIP	
HOME PHONE	SOC.SEC. #	MARITAL STATUS	DATE OF BIRTH	AGE	SEX
WORK PHONE	EMPLOYER		OCCUPATION		
EMERGENCY CONTACT	RELATIONSHIP		PHONE		
REFERRING PHYSICIAN	ADDRESS		PHONE		
PRIMARY HEALTH INSURANCE		NAME OF INSURED / DATE OF BIRTH			
ID # ON CARD.	GROUP #		SOC.SEC. # OF INSURED		
SECONDARY HEALTH INSURANCE		NAME OF INSURED / DATE OF BIRTH			
ID # ON CARD	GROUP #		SOC.SEC. # OF INSURED		

IS THIS A AUTO ACCIDENT CLAIM? [] YES [] NO IF YES, PLEASE COMPLETE THIS SECTION

INSURANCE CARRIER	ADDRESS	
DATE OF ACCIDENT	CLAIM / FILE #	PERSON TO CONTACT / PHONE #

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ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATION

I hereby authorize Advanced Physical Therapy to release such information as required by my insurance company/attorney in order to secure my insurance benefit. I also authorize my insurance company to pay Advanced Physical Therapy directly for services that they agree to bill for me. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Advanced Physical Therapy's policy is that payment is due when services are rendered. A \$25 fee will be assessed for all returned checks. I also understand that if this account is not paid in a timely fashion, that I will be responsible for any collection/and or reasonable attorney fees incurred in the attempt to collect this debt.

I am aware that I am ultimately responsible for all services charged to me and I understand that these services are to be paid in a timely fashion regardless of any insurance companies with which I may participate with.

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date: _____
(if under age 21, and adult must sign.)