

REGISTRATION FORM

Date: \_\_\_\_\_

PERSONAL INFORMATION

Name: \_\_\_\_\_ Telephone #'s: (Hm): \_\_\_\_\_  
 Address: \_\_\_\_\_ (Wk): \_\_\_\_\_  
 \_\_\_\_\_ Zip: \_\_\_\_\_ (Cell): \_\_\_\_\_  
 S.S.# \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Marital Status (circle one): M S D SEP W If married, Spouse's Name: \_\_\_\_\_  
 Are you? Employed \_\_\_\_\_ Student \_\_\_\_\_ Employer/School Name: \_\_\_\_\_  
 Your Occupation/Field of Study: \_\_\_\_\_

INSURANCE INFORMATION

Is your injury a result of an accident? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes, date of accident: \_\_\_\_\_ State of accident: \_\_\_\_\_  
 Was accident: Auto \_\_\_\_\_ Work \_\_\_\_\_ Other (List): \_\_\_\_\_  
 Have you filed an Application for Benefits with the Insurance Company? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Do you have an attorney? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If yes: Attorney's Name and Phone #: \_\_\_\_\_

Primary Insurance Company Name: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

**Please provide a copy of your insurance cards to the receptionist for copying.**

PATIENT RELEASES

I hereby authorize H/S Therapy Associates, Inc. to: 1) provide me with physical therapy treatments and 2) to furnish the above named insurance company(s) with any medical information regarding this injury that may be necessary to process all claims relative to the physical therapy treatments received. I request that payment of authorized insurance benefits for the physical therapy treatments I receive at H/S Therapy Associates, Inc. be made on my behalf directly to H/S Therapy Associates, Inc. I understand that I am legally responsible for any charges for physical therapy services received at H/S Therapy Associates, Inc. which are unpaid by my insurance coverage and deemed by them to be my personal responsibility to pay. Once I am billed for items that are my personal responsibility to pay, I understand that payment shall be due within 30 days in order to avoid a service charge of 5% per month. I understand that a payment schedule will be made available to me should I desire. I agree to pay H/S Therapy Associates a \$25.00 processing charge for any check that I issue that is returned by the bank. Further, if my account is referred for collection, I understand that I will be responsible for collection costs in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees. I understand that all information provided by any member of the H/S Therapy Associates staff regarding my insurance coverage is not a guarantee of my medical benefits. I will not hold H/S Therapy Associates responsible for any misinformation they may receive from my insurance company regarding coverage for outpatient physical therapy care. I have been advised to contact my insurance company directly to verify my benefits for outpatient physical therapy care. A photocopy of the above releases shall be considered as effective as the original.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_