

**Maryland Physical Therapy
Patient Registration Form**

Patient Name _____ Date of Birth _____ Age _____
Address _____ Social Security Number _____
City, State, Zip _____ Home Phone _____
Employer _____ Work Phone _____
Cell Phone _____ E-mail _____
Emergency Contact _____ Emergency Phone _____
Referring Physician _____ Doctor's Phone _____
Primary Care Physician _____ PCP Phone _____
Diagnosis code: _____ Date of Onset/Injury _____

(To be filled in by staff)

Have you had prior therapy? No Yes, for which condition? _____

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Employment Status: Full time ___ Part time ___ Unemployed ___ Retired ___

Is this problem related to a motor vehicle accident? No Yes

Is this problem related to a work injury? No Yes

**If you answered yes to either of the above, please complete the following
REQUIRED INSURANCE INFORMATION:**

PIP or Worker's Compensation Carrier _____ Phone _____
Adjustor's Name _____ Claim Number _____
Claims Address _____ City, State, Zip _____
Attorney name _____ Phone # _____

REQUIRED HEALTH INSURANCE INFORMATION:

Primary Insurance _____ Member Number _____
Relationship: Self Spouse Parent Other
Secondary Insurance _____ Member Number _____
Relationship: Self Spouse Parent Other

Information on Insurance Policy Holder (If other than self)

Last Name _____ First Name _____ MI _____
Social Security # _____ Date of Birth ___/___/___
Address _____ City _____
State _____ Zip _____ Home Telephone _____

Maryland Physical Therapy

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Maryland Physical Therapy* to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian _____ Date __/__/__

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including private insurance and any other health plans, to *Maryland Physical Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian _____ Date __/__/__

Scheduling and Cancellation Policy

Maryland Physical Therapy reserves the right to bill a \$25 no show fee **if we are not** notified that you are unable to attend your scheduled appointment. If you cannot make your scheduled appointment time, we ask that you notify us as early as possible so that we may accommodate other patients. Consistency in treatment is important to your rehabilitation outcome, therefor multiple cancellations may result in termination of your treatment or a loss of prime (desired) schedule time.

Patient/Guardian _____ Date __/__/__

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when the services are rendered. A co-pay if required by your health insurance carrier will be due at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any funds are paid in excess by your carrier, you will be promptly refunded the credit.

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of Privacy Practices from Maryland Physical Therapy. The notice is dated April 14, 2003.

Date: _____

In lieu of patient signature, I, _____, a staff member of Maryland Physical Therapy, state that

_____ has been given our current Notice of Privacy Practices.

Date: _____