REGISTRATION FORM

(Please Print) REFERRING PHYSICAN ___________________________

Today's Date _____/_____/_____ Primary Care Physician _________________________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	City	State	Zip Code	Home Phone ( ) Cell Phone ( )

Social Security Number	EMAIL:

Occupation	Employer	Employer Phone No. ( )

Chose Office Because/Referred to Office by (Please check one box) ❑ Dr. ____________________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________________

Other Family Members Seen Here: ____

INSURANCE INFORMATION (DO NOT FILL OUT IF YOU HAVE YOUR INSURANCE CARD)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone ( )
Is this person a patient here?	❑ Yes ❑ No		Cell Phone ( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is patient covered by insurance? Circle one: Med Auto WC DATE OF INJURY: STATE: NJ PA ____

Indicate primary insurance name: Lawyer Name:

Phone:

Member Services phone number: Address:

Address: ❑ Other ____________________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to BREAKTHRU Physical Therapy. I understand that I am financially responsible for any balance. I also authorize BREAKTHRU Physical Therapy and/or insurance company to release any information required to process my claims.

X ____

PATIENT/PARENT/GUARDIAN SIGNATURE DATE

Patient name:_________________________
DOB:___________

CONSENT FOR TREATMENT:

I give my consent for Breakthru Physical Therapy to furnish physical therapy to myself or dependent that is considered necessary and proper for treatment of myself or dependent's physical condition.
Initials__________

ASSIGNMENT OF BENEFITS:

I authorized payment of Medicare/Insurance benefits to be made directly to Breakthru Physical Therapy on my behalf for physical therapy services rendered. I authorize Breakthru Physical Therapy to release my protected health insurance for treatment and billing purposes.
Initials__________

NOTICE OF PRIVACY PRACTICES:

I have received a written copy of Breakthru Physical Therapy's Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by Breakthru Physical Therapy, my rights as the patient, and Breakthru Physical Therapy's legal duties with respect to my protected health information.
Initials__________

FINANCIAL POLICY:

As a courtesy, Breakthru Physical Therapy will pre-verify your insurance benefits. Please note: Unless you have secondary insurance all co-pays, deductibles, and/or co-insurance is the responsibility of the patient, parent or guardian of a dependent. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you when we have received an "Explanation of Benefits" from your insurance carrier. You are encouraged to obtain the details of your plan's exact coverage for verification.
*Payment methods include: cash, check or money order. Returned checks and balances older than 90 days are subject to additional charges.

Initials_________

CANCELLATION/NO-SHOW POLICY:

Breakthru Physical Therapy urges you to keep every appointment, as consistent treatment will promote a speedy recovery. We require 8 hours if you need to cancel an appointment. Patients who cancel without proper notice or fail to show up for scheduled appointments will be subject to a $25 charge.
Initials_________

SIGNATURE ON FILE

I have read, understand and agree with the above policies and procedures.

___________________________________ ___________
Patient/Parent/Guardian Signature Date

___________________________________ ___________
Reviewed By Date

___________________________________ ___________
Witness Date