



For Office Use Only: MD MT V

## Physical Therapy Registration Form

**Patient Information:**

Patient Name: Last		First	MI
SS#	Date of Birth: ____/____/____	Age:	<input type="radio"/> Male <input type="radio"/> Female
Street Address:	City/State/Zip	Phones – Home: Cell: Work:	
Email:		Circle One: Single / Mar / Div / Sep / Widow	
Emergency Contact:	Emergency Contact Phone:	Relationship to Patient:	

**Referring Physician Information:**

Physicians Name:	Address:	City/State/Zip
Phone:	<b>Being Referred For:</b> <input type="radio"/> Knee <input type="radio"/> Hip <input type="radio"/> Foot <input type="radio"/> Shoulder <input type="radio"/> Lumbar <input type="radio"/> Cervical <input type="radio"/> Other _____	
Fax:		
Primary Care Physician:	<b>Did This Injury/Issue Require Surgery:</b> <input type="radio"/> Yes <input type="radio"/> No If yes, date of surgery _____ Home Physical Therapy _____	

I certify that the information I have provided is correct to the best of my knowledge. I will not hold my Therapist or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Furthermore, I \_\_\_\_\_ (print name) give my consent for Breakthru Physical Therapy to provide rehabilitative services to me or the named patient.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient



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Name: \_\_\_\_\_ **DOB:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
*Last First mm dd yyyy*

E-Mail: \_\_\_\_\_ *Please print clearly* \_\_\_\_\_ *Zip Code*

**Please tell us about your interests so we can help you get the most out of what BREAKTHRU has to offer you!**

Please check all you are interested in hearing about:

- Receive our Newsletter**
- Receive Special Offers & Coupons**
- Massage**
- Fitness Membership Information**
- Personal Training**
- Sports Performance**
- Weight Training**
- Weight Management and/or Fat Loss**
- Yoga/Tai Chi**
- Boot Camp**
- TRX**



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**Acknowledgement of Financial Responsibility Practices  
And  
Acknowledge of Notice of Privacy Practices (HIPAA)**

By my signature below I acknowledge:

- **My receipt and/or acceptance of the Notice of Financial Responsibility Practices and Notice of Privacy Practices (HIPAA) for BREAKTHRU Physical Therapy.**

When necessary to process insurance claims for medical treatment or services rendered to me, I expressly authorize:

- The release of any/all medical information about me by any holder of said information to any insurance carrier who may provide financial assistance for this treatment or service;
- The release to the Centers for Medicare and Medicaid and/or to the Health Care Financing Administration and its agent(s) of any medical information necessary to determine benefits;
- The payment by my insurance carrier(s) of insurance and/or Medicare benefits directly to BREAKTHRU Physical therapy for services rendered.

I accept financial responsibility to BREAKTHRU Physical Therapy if my insurance does not pay for my services and/or the remaining balance(s) from what my insurance company has paid.

\_\_\_\_\_  
*Print Patient Name*

\_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

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\_\_\_\_\_ was given a copy of the Notice of Financial Responsibility and the Notice of Privacy Practice (HIPAA).

\_\_\_\_\_  
*Print Staff Name*

\_\_\_\_\_  
*Staff Signature*

\_\_\_\_\_  
*Date*

Or

\_\_\_\_\_ refused to sign.

\_\_\_\_\_  
*Print Staff Name*

\_\_\_\_\_  
*Staff Signature*

\_\_\_\_\_  
*Date*