



S.P.O.R.T. PHYSICAL THERAPY PATIENT REGISTRATION

PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

Date of Birth: _____ SSN: _____ Gender: male female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Marital Status (circle): Married Spouse's Name: _____ Single Divorced Widowed Separated Other

Employer: _____ Occupation: _____

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Address: _____ Phone Number: (____) _____

PREFERRED APPOINTMENT REMINDER METHOD:

Text Message Email Phone Call Please specify (home, cell, work, or other): _____

INSURANCE / GUARANTOR INFORMATION

Have you verified your physical/occupational therapy benefits with your insurance? No Yes

It is your responsibility to know your insurance benefits and to know which providers are in network and out of network based on your insurance plan. As a courtesy to you, we will try to provide you with the most up-to-date information about your benefits (we will only verify your copay and visit limits), but ultimately you are expected to know what these benefits are, including your deductible. Please Initial: _____

Have you had physical/occupational therapy this calendar year? No Yes

If yes, how many treatments have you received this year? _____

Are you currently or have you recently been under the care of Home Health? No Yes

If yes, discharge date? _____

(Complete insurance information only if you do not provide us a copy of your card)

Primary Insurance: _____ Policy Number: _____

Policyholder: _____ Date of Birth: _____ SSN: _____

Secondary Insurance: _____ Policy Number: _____

Policyholder: _____ Date of Birth: _____ SSN: _____

Do you have healthcare coverage through Nimiipuu Health? No Yes

Patient Name: _____ Date of Birth: _____

Work-Related Injury: No Yes If Yes, Date of Injury: _____

Industrial Insurance Company: _____ Claim Number: _____

Employer: _____

Auto Accident Injury: No Yes If Yes, Date of Injury: _____

Responsible Party's Insurance*: _____ Claim Number: _____

Policyholder Name: _____

(*SPORT Physical Therapy does not bill third-party payers)

If patient is under the age of 18, please complete:

Guarantor Name: _____ Date of Birth: _____ SSN: _____

Relationship to Patient: _____ Phone Number: _____

Address (if different than patient): _____

Employer Name: _____ Work Phone: (____) _____

REFERRAL INFORMATION

How did you hear about SPORT Physical Therapy: Physician Friend/Family Internet Other

Referring Doctor: _____ Primary Care Physician: _____

Diagnosis/Chief Complaint(s): _____

Date of Injury/Onset: _____ Did You Have Surgery? No Yes If Yes, when? _____

ASSIGNMENT OF BENEFITS / SIGNATURE ON FILE

I certify that all information provided above is true to the best of my knowledge. I understand that if any of the above information changes, it is my responsibility to inform SPORT Physical Therapy Clinic of these changes.

I, the undersigned, consent to the use of Protected Health Information (PHI) for treatment and payment of the above-named person. I authorize SPORT PHYSICAL THERAPY CLINIC to bill my insurance and assign directly to SPORT PHYSICAL THERAPY CLINIC all medical benefits/payments, if any, otherwise payable to me for services and supplies rendered. I understand that SPORT PHYSICAL THERAPY CLINIC will share patient PHI according to the federal and state law for treatment and payment, as well as in accordance with its Notice of Privacy Practices. I hereby authorize SPORT PHYSICAL THERAPY CLINIC to release all information necessary to secure payment of benefits to my insurance company. I authorize the use of this signature on all insurance submissions. This authorization is in effect until I choose to revoke it. I acknowledge and understand that I am financially responsible for all charges whether or not they are reimbursed by my insurance company. I acknowledge and understand that all charges remaining after insurance reimbursement are my financial responsibility.

PATIENT/GUARDIAN/REPRESENTATIVE SIGNATURE

DATE