

GAINESVILLE PHYSICAL THERAPY

NEW PATIENT REGISTRATION

ASSIGNED TO: _____

APPOINTMENT DATE: _____

PLEASE PRINT

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth / /	Social Security Number	Sex (circle one) M F
Home Address		City	State	Zip Code	Email Address
Home Phone	Work Phone	Cell Phone	Fax	Other Contact Name / Phone	
Marital Status Single () Married () Divorced () Legally Separated () Widowed ()			Student Status Full Time () Part Time () Non Student ()		
Employment Status Not Employed () Full Time () Part Time () Retired ()		Employer / School Name		Title / Position	
Work Street Address		City	State	Zip Code	

REFERRING PHYSICIAN INFORMATION

Last Name	First Name	MI	Address	Phone Number
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PRIMARY CARE PHYSICIAN (PCP) INFORMATION

Last Name	First Name	MI	Address	Phone Number
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EMERGENCY CONTACT INFORMATION

Name (First and Last)	Relationship	MI	Home Phone Number	Cell Phone Number
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REASON FOR TODAY'S VISIT

Is this injury / condition related to your.....					
Work Related ? Yes () No ()	Car Accident ? Yes () No ()	Accident At Home? Yes () No ()	Other Accident ? Yes () No ()	Date of Injury	Please indicate the date of 1 st symptom
If Work or Auto Related, Please Provide the Name of Adjuster or Case Manager				Phone Number of Adjuster or Case Manager	

Please describe your injury/ accident/ illness

PRIMARY INSURANCE INFORMATION

Primary Insurance Company	Primary Insurance Company Policy Holder (if other than patient)	
Policy Holder Date of Birth	Policy Holder Social Security Number	Policy Holder Relationship To Patient

SECONDARY INSURANCE INFORMATION

Primary Insurance Company	Primary Insurance Company Policy Holder (if other than patient)	
Policy Holder Date of Birth	Policy Holder Social Security Number	Policy Holder Relationship To Patient

OVER

RESPONSIBLE PARTY STATEMENT

As the Responsible Party, I agree that all charges that are not directly paid by my insurance company will be MY RESPONSIBILITY

Signature of Responsible Party : _____

Date: _____

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Gainesville Physical Therapy in the event they file insurance on my behalf. A copy of this assignment shall be considered as effective and valid as the original.

I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default in payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt, including but not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for the unpaid balances over 90 days old.

I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. I understand I may need to complete and return additional forms from/to Gainesville Physical Therapy according to governing laws and policies of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I do hereby consent to such treatment by the authorized personnel of Gainesville Physical Therapy as would be dictated by prudent medical practice/treatment of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Authorized Signature: _____

Date: _____