

# Patient Express Registration

South Aiken Physical Therapy

Today's Date: \_\_\_\_\_

## 1. Patient Info

IMPORTANT: Please Fill-Out This Form Completely & Legibly (Do not leave any items blank)

Your Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender: \_\_M\_\_F

Home Address \_\_\_\_\_

Your Hm Phone ( ) \_\_\_\_\_ Cellular ( ) \_\_\_\_\_

Email Address \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Ph \_\_\_\_\_

My condition is related to:  Work  Auto Accident (state \_\_\_\_\_)  Other: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Why did you choose this clinic? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Social Security # \_\_\_\_\_

Status: \_\_Single\_\_Married

Occupation \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Ph \_\_\_\_\_

Family MD \_\_\_\_\_

Family MD Ph \_\_\_\_\_

## 3. Important Info

We are very committed to you and your goals. We will reserve appointment times for you that allow you the appropriate amount of therapist time for your needs. If you cannot keep your appointment, please call with 24 hours notice if possible so that someone else might benefit from that time. Failure to provide 24 hours notice will result in a fee to you.

*Nothing will be charged unless you cancel with less than a 24-hour advance notice (\$10 fee) or fail to show (\$25 fee).*

## 2. Payment Info

(check only one box)

### CASH PAYERS (30% Discount)

- I am paying out-of-pocket (cash) for services. Please give me a 30% discount.
- I have an attorney but want the 30% discount by paying up front. I'll get reimbursed after my case settles.

### NON-CASH PAYERS

- I have insurance and would like you to deal directly with them. I will assign my benefits over to you (must complete the "Assignment of Benefits" form). I understand that I am responsible for any deductible, co-payment or co-insurance associated with my insurance plan. I also understand that my insurance plan may not cover all services received in Physical Therapy and that I am responsible for any non-covered expenses.
- I was injured on the job and my employer will be paying the bills. The adjusters name is:

Ph# \_\_\_\_\_

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring MD, and/or other third party payer.

Patient Signature Required \_\_\_\_\_ Date \_\_\_\_\_