

PERFORMANCE PHYSICAL THERAPY PATIENT REGISTRATION

PATIENT INFORMATION (Please **Print** Clearly)

Patient Name: _____ Birth Date: _____
Last First MI

Social Security # _____ - _____ - _____ Sex: M F

Address: _____
Street/PO Box Apt # City State Zip

Phone: (____) _____ Cell/Alternate Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Parent (if **minor** or **college student**)/Responsible Party Name: _____

Address/Phone _____ (____) _____

REASON FOR VISIT/Area of body to be treated: _____ Date of onset: _____

Primary Physician: _____ Referring Physician: _____

INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's Name: _____

Consumer/Subscriber# _____ Group Plan # _____ Co Pay _____

Secondary Insurance: _____ Subscriber's Name: _____

Consumer/Subscriber# _____ Group Plan # _____

If MOTOR VEHICLE ACCIDENT (MVA) OR WORK RELATED, complete next section...

Date of Injury: _____ **Work Related:** Yes ___ No ___ **MVA:** Yes ___ No ___

MVA Insurance Company/Address: _____

Phone (____) _____ Adjuster: _____

Motor Vehicle Accident Claim # _____

WA State **L&I Claim #** _____ Employer at time of Injury _____

Have you had Physical Therapy at any other Clinic using this claim number? Yes No

If **Self Insured L&I**, please provide insurance name, address & phone number below...

Please sign CONSENT & RELEASE ON REVERSE

Staff _____ Eval Date _____ Therapist _____

Revised 08/2007

ALL PATIENTS PLEASE READ AND SIGN BELOW

I, consent to treatment and authorize the use of this signature on insurance claims pertinent to physical therapy treatments received at Performance Physical Therapy. I understand that as a courtesy, Performance Physical Therapy will bill my insurance company directly, but that I am personally responsible for any co-pays, deductible, or balances remaining after insurance consideration.

Date: _____

Signature of Patient or responsible party (if patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF OUR "NOTICE OF PRIVACY PRACTICES" & CONSENT FOR USE & DISCLOSURE OF PHI

Law requires us to make a good faith effort to obtain your signature signifying you have been offered a copy of our Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. The Notice provides a description of our treatment, payment, healthcare operations, and the uses and disclosures we may make of your protected health information. It explains in detail the procedures we use to protect your healthcare and personal information. Please take the time to read it carefully and completely.

By my signature below I acknowledge receipt of the Notice of Privacy Practices. I understand also that I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Patient or legally authorized individual signature

Date

Time

MEDICARE PATIENTS PLEASE COMPLETE THIS SECTION

IF YOU ARE A MEDICARE PATIENT PLEASE COMPLETE THE FOLLOWING...

LIFE TIME AUTHORIZATION

Provider's Name: Performance Physical Therapy, Inc.
2075 Barkley Blvd, Suite 200, Bellingham, WA 98226 or
1616 Cornwall Ave, Bellingham, WA 98225

Patient's Name: _____

Patient's Medicare #: _____

Patient's Address: _____

This authorization is good until revoked/rescinded by patient.

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date: _____ Patient's Signature: _____

Please sign CONSENT & RELEASE ON REVERSE

Staff _____

Eval Date _____

Therapist _____

Revised 08/2007