Freehold Physical Therapy LLC

PATIENT REGISTRATION FORM

Last Name: ____________________________________ First Name: _________________________________ MI __________

Date of Birth: __________________ ___ Male ___ Female Social Security Number: _________________________

Marital Status: _____ Single _____ Married _____ Partnered _____ Widowed _____ Separated _____ Divorced

Drivers License Number : ____ State of License : ____________________________

How did you hear about Freehold Physical Therapy : ____

Mailing Address: _______________________________________ City: ____________________ State : _______ Zip: ____________

Home number: ________________________ Cell # _______________________ e-mail address ____________________________________

Reason for Visit:

____

Work related: ____ Yes ____ No Car Accident ____ Yes ____ No

Have you had Physical Therapy this year ____ Yes ____ No If yes how many visits ____________

Physician Information:

Referring Physician: ________________________________ Phone: __________________________

Insurance and Billing Information:

Please circle one:

NF (No fault) **WC** (Worker's Comp) **MC** (Medicare) **HMO** **PPO** **SP** (Self Pay)

Primary insurance carrier: ____Member ID: __________________________________

Group#:___________________________________ Insurance Co. Phone # ____

Insured Name:______________________ Date of Birth: ____________________ SSN:__________________________________

Secondary insurance carrier: ______________________________________ Member ID: _________________________________

Group#: _____________________________

Insured Name: _______________________ Date of Birth: _____________________ SSN: __________________________________

Auto / Worker's Comp

Insurance Company : ____

Claim Number : _____________________________________ Policy # : ____

Adjuster :____ Phone # ______________________________

☐ I do not have insurance.

I agree to pay today for the services provided by Freehold Physical Therapy LLC.

Assignment and Release:

I hereby authorize my insurance benefits to be paid directly to Freehold Physical Therapy LLC. I am financially responsible for the balance due. I understand that any and all non-covered services are my sole financial responsibility. I also authorize Freehold Physical Therapy or insurance company to release information required for this claim. I also understand that if my insurance requires a referral, it is my responsibility to provide one to Freehold Physical Therapy LLC, at the time of service.

I, the patient/patient's legal representative, hereby grant permission to Freehold Physical Therapy LLC to perform such examinations and medical or therapeutic procedures as may be deemed professionally necessary for my/the patient's diagnosis and treatment.

Signature___________________________________ Printed Name: _________________________ Date: _____________________

Our office takes every effort in protecting your personal information.