jacksonville physical therapy

PATIENT REGISTRATION AND AUTHORIZATION

Name_____ Date of Birth_____/_____/_____
preferred phone #_____ other phone #_____Sex: M / F
email: _____ Marital status: S M W D (circle one)
Mailing Address_____City_____Zip_____
Social Security #_____ Employer_____
Emergency contact _____ phone # _____
Referring physician_____ Primary physician_____
Payment options (check one):
__1. I will be paying personally for my physical therapy treatments. (skip to the *Agreement* below.)
__ 2. Please bill my insurance company for payment. (Complete the following.)

→ If you have a card(s) for copying, complete only the name of your insurance(s).

***PRIMARY INSURANCE*_____ Phone_____**
Address _____City, State, Zip_____
Subscriber ID/Policy #_____ Group/Claim #_____
***SECONDARY INSURANCE* _____ Phone_____**
Address_____ City, State, Zip_____
Subscriber ID/Policy #_____ Group/Claim #_____
Are you the "subscriber"? Yes __ No __
If not, what is your relationship to the subscriber?
Spouse __ Child __ Other __ (explain) _____
Subscriber Name_____ Subscriber's Date of Birth ____/____/____

Is your injury a [ ]Worker's Compensation Claim, a [ ] Motor Vehicle Accident or a [ ]Personal Injury Claim? Date of injury ____/____/____
Do you have an attorney involved? If so, print your attorney's name, address and phone number.
Attorney name:_____ phone #_____ fax # _____
Attorney's address: _____
If WC, full name of employer_____
Insurance name _____ Phone # _____
Claim # _____
Claim Adjuster_____ Phone # _____
Send Claims to: _____ Fax # _____
_____
_____

Agreement:
I authorize payment to be made directly to Jacksonville Physical Therapy. I authorize release of my physical therapy case information to the above insurance companies, physicians and attorney, if applicable. I understand it is my responsibility to provide current and correct insurance information.

Patient's signature_____ Date_____

Guarantor's signature_____ Date_____