BENTZ PHYSICAL THERAPY REGISTRATION FORM

Name _____ Home/Cell Phone _____

Address _____City, State, Zip _____

Email address _____ Date of Birth ___/ ___/ ____ Last 4 of SS# _____

Single Married Student (P/T or F/T) Occupation _____ Employer _____

*If patient is under 18 years of age, Name / Ph. # of Responsible Party _____

Emergency Contact Name _____ Phone _____ Relationship _____

PAYMENT INFORMATION: (NOT APPLICABLE FOR WORKER'S COMP OR SELF-PAY PATIENTS)

Insurance Company _____ ID# _____ Group# _____

Insurance Policy Holder _____ Relationship _____ Date of Birth ____/____/____

Secondary Insurance Company _____ ID# _____ Group # _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

_____ (**INITIAL**) I authorize Bentz Physical Therapy to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize payment of medical benefits to Bentz Physical Therapy. I understand that I am financially responsible for all copayments, deductibles, co-insurance, and services NOT COVERED under my benefits plan. I have received and understand the credit and collection policy of this company and agree to abide by the policy stated therein.

MY CONDITION INFORMATION:

□Auto/Personal Injury: Date of Injury ___/ ___/ ___

□ Surgery: Date ___/ ___/ ___ Type? _____

□Work Related: Date of Injury ___/ ___/ ___ Adjustor Name _____ Phone #_____

□No Injury, I just have pain or difficulty.

REFERRAL INFORMATION: (How did you hear about us? Please give details.)

□Physician: Referring _____ Primary Care _____ □Insurance/Directory

□Friend/Family_____ □Internet Search_____□Social Media_____ □Other _____

PATIENT POLICY AND H.I.P.A.A. CONSENT (A copy can be provided upon request.)

_____ (**INITIAL**) I acknowledge that I have been provided an opportunity to review the Patient Policy/H.I.P.A.A. consents.
I designate the following individual (this does not included yourself, referring doctor or insurance company) to have access to information about me that is created by or on behalf of Bentz Physical Therapy.

Authorized Individual Name _____ Relationship_____

Authorized Individual Name _____ Relationship_____

COMMUNICATION CONSENT

I consent to receiving communication from Bentz Physical Therapy to the phone number or email address that I have provided. I understand that this may include; health notifications, appointment information, announcements and billing.

_____ Phone _____ Voicemail _____ Text Messaging _____ Email

I have read and completed this information sheet and certify this information is true and correct to the best of my knowledge.

Signature _____ Date _____