REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:	Social Security no.:	Home & cell phone no work.: ( ) ( )			
P.O. box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no.: ( )			

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet/ ❑Facebook ❑ Website

❑ Other _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Millbrook Physical Therapy, PC Policies:

There is a **$50.00** fee for all **missed** appointments without **24 hour notice**.

CO PAYS ARE COLLECTED PRIOR TO TREATMENT

We require a credit card on file for all high deductible plans

We accept check, cash, & credit card; We also offer "Auto Charge" the front desk has information on this for you.

There is a **$10.00** billing fee for any collection of unpaid copayments / coinsurance, deductible.

There is a **$20.00** returned check fee.

There is a **$10.00** fee for medical records.

Please let the receptionist know if you would like a copy of the below policies

I have read and have been offered a written copy of the policies below. I understand, and agree to the terms of them:

Clinic Policy Regarding Visits & Fees (above)	Please Initial _____
Medicare Payment Policy Agreement:	Please Initial _____
MOST HIPPA Policy	Please Initial _____

Please remember that insurance is a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.** All co-insurance, co-pays, deductibles, and any amount the patient is responsible for will be paid by the end of each visit. 1.5% interest will be accrued on all balances 30 days past due.

If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to Millbrook Physical Therapy, PC.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.**

I HAVE READ AND ACKNOWLEDGE THAT ALL OF THE ABOVE INFORMATION IS CORRECT AND I AGREE TO THE ASSIGNMENT S AND FINANCIAL RESPONSIBILITIES STATED ABOVE.

X _____ **Date** _____

Signed (patient, parent, or guardian if under 18 years of age)

IN CASE OF EMERGENCY

CONTACT NAMEAND NUMBER:_____