

FITNESS CENTER PHYSICAL THERAPY

REGISTRATION – PLEASE COMPLETE
READ AND SIGN POLICY / AUTHORIZATION ON THE BACK

DATE: _____ REFERRING PHYSICIAN: _____

FAMILY OR PRIMARY CARE PHYSICIAN: _____

PATIENT'S NAME: _____

PARENT'S NAME IF PATIENT IS A MINOR: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME OR CELL PHONE: _____ WORK PHONE: _____

SOCIAL SECURITY NO : _____

PATIENT'S DATE OF BIRTH: _____ PATIENT'S MARITAL STATUS: _____

EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ CITY AND ZIP: _____

ON THE JOB INJURY? _____ AUTO INJURY? _____ DATE INJURED: _____

WAS A WORKERS COMP. CLAIM FILED? _____ AUTO CLAIM FILED? _____

NAME OF CASE MANAGER IF APPLICABLE: _____ PHONE: _____

.....

HOW DID YOU HEAR ABOUT OUR CLINIC?

BILLING INFORMATION

PLEASE PRESENT YOUR INSURANCE CARD AT THE FRONT DESK

PLEASE INFORM US OF ALL INSURANCE COVERAGE THAT MAY APPLY

COPY OF CARD ATTACHED: _____ OR COMPLETE INFORMATION BELOW:

NAME OF INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____

POLICY, GROUP, AND I.D. NUMBERS: _____

FINANCIAL POLICY

FITNESS CENTER PHYSICAL THERAPY IS A FREE STANDING OUTPATIENT PHYSICAL THERAPY CLINIC PROVIDING PROFESSIONAL SERVICES BY LICENSED PHYSICAL THERAPISTS.

AS A COURTESY TO OUR PATIENTS, INSURANCE CLAIM FORMS WILL BE PREPARED AND SENT TO YOUR INSURANCE COMPANY. A STATEMENT FOR YOUR DEDUCTIBLE AND CO-PAY AMOUNTS AND/OR ANY NON-COVERED CHARGES WILL BE SENT TO YOU EACH MONTH AND BALANCES ARE DUE WITHIN 30 DAYS UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

WORKERS COMPENSATION CLAIMS WILL BE BILLED DIRECTLY TO THE CARRIER IN ACCORDANCE WITH MICHIGAN LAW. PAYMENT OF ANY DISPUTED OR DENIED CLAIM WILL BE YOUR RESPONSIBILITY.

PLEASE BE ADVISED THAT THE CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY IS A SEPARATE CONTRACT FROM THAT BETWEEN YOU AND OUR CLINIC. YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED, UNLESS OTHERWISE PROVIDED BY LAW.

.....

AUTHORIZATION TO PAY / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY FITNESS CENTER PHYSICAL THERAPY FOR ALL PHYSICAL THERAPY SERVICES RENDERED. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE AMOUNTS, AND NON-COVERED SERVICES.

I REQUEST PAYMENT OF THE MEDICARE BENEFITS ON MY BEHALF DIRECTLY TO FITNESS CENTER PHYSICAL THERAPY. I CERTIFY THAT THE INFORMATION GIVEN FOR PAYMENT UNDER TITLE 18 OF THE SOCIAL SECURITY ACT IS CORRECT.

I HEREBY AUTHORIZE FITNESS CENTER PHYSICAL THERAPY TO OBTAIN AND RELEASE INFORMATION REGARDING MY CONDITION AND/ OR TREATMENT ONLY TO MY PHYSICIAN, INSURANCE COMPANY, OR EMPLOYER (IF WORKERS COMP). F.C.P.T. AGREES TO COMPLY WITH ALL HIPAA AND STATE PATIENT PRIVACY REQUIREMENTS.

I HAVE READ AND UNDERSTAND THE ABOVE AUTHORIZATION AND INFORMATION SECTIONS OR HAVE HAD THEM READ AND EXPLAINED TO ME TO MY SATISFACTION.

SIGNATURE: _____ **DATE:** _____

PARENT OR GUARDIAN SIGNATURE IF PATIENT IS A MINOR : _____