PATIENT REGISTRATION FORM

Thank you for choosing Alternative Therapy. Please Print. All information will be confidential

Date:_____ Home Phone:_____ Cell Phone: _____

Last Name_____ First Name: _____ M.I.:_____

Florida Address:_____ City: _____ Zip: _____

Out-of State Address: _____ City/St: _____ Zip: _____

Email: _____ Sex: ☐ Male ☐ Female

Social Security: _____ Date of Birth: _____ Age: _____

Employer: _____ Occupation: _____ Work Phone:_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Physician: _____ Phone: _____

PREVIOUS P.T. THIS YEAR? ☐ Yes ☐ No If yes, how long?_____

How did you hear about us? _____

In case of emergency who should be notified?_____ Phone:_____

MEDICAL INSURANCE INFORMATION

Insurance (circle one): Medicare Commercial PPO Workmen's Comp. Car Ins. Non-PPO

Insurance Name: _____ Phone: _____

Insurance ID #: _____ Group #: _____Date of Accident:_____

Policy Holder's Name: _____ Circle One: Workers Comp. or Auto

Secondary Insurance Name: _____ Policy #: _____

ALL UNPAID ACCOUNT BALANCES WILL BE CONSIDERED DELINQUENT SIXTY (60) DAYS FROM THE DAY OF CHARGE. ANY DELINQUENT ACCOUNT REFERRED TO A COLLECTION AGENCY WILL BE RESPONSIBLE FOR THE COST OF THE COLLECTION INCURRED BY ALTERNATIVE P.T., INC. INCLUDING ATTORNEY'S FEE. I hereby authorize my insurance company, including private medical insurance and other health plan to pay benefits to which I am entitled for services rendered by Alternative P.T., Inc. This will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I authorize Alternative P.T., Inc. to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also authorize the release of medical reports and other pertinent information to my referring physician or any other medical personnel involved with the prescribed treatment initiated on this date.

I, _____, have read and fully understand the above policy.

_____ _____

Signature of patient (Parent if minor) Date