

WAUCONDA PHYSICAL THERAPY PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____ DOB: _____ SS #: _____
(First) (Middle Initial) (Last)

Street: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

How did you hear about us: _____ Email Address: _____

Emergency Contact: _____ Phone: _____
(Relation)

INSURANCE INFORMATION

*****PLEASE PRESENT INSURANCE CARD AND DRIVERS LICENSE TO FRONT DESK *****

Insurance Company: _____ Policy # _____

Phone _____ Address _____

Primary Insured: Self _____ Other _____ Name: _____ DOB _____

For Work Comp or Auto Accident Only

(We will not bill 3rd parties for Auto Accidents)

Work Comp? Auto Accident? (Circle 1)

Claim # _____ Date of Injury _____

Attorney Name: _____

PLEASE READ AND SIGN BELOW

- 1.) I consent to and authorize Wauconda Physical Therapy to administer physical therapy treatment to me/my dependent.
- 2.) I authorize payment by my insurance company to Wauconda Physical Therapy named in claims submitted on my behalf.
- 3.) I authorize the release of medical information to process claims on my behalf.
- 4.) I authorize the release medical information to:
Name: _____ Relationship: _____
- 5.) I authorize communications re: appointments via phone, text or email.
- 6.) I understand that I am responsible for any co-pays, deductibles, coinsurance and charges not covered by my insurance.
- 7.) I have read the Notice of Privacy Practices.

****Appointments cancelled or rescheduled without 24-hour notice may be subject to a \$50.00 cancellation fee. Missed appointments will be charged a \$50.00 "No Show" fee. Initials _____**

Patient/Legal Guardian Signature

Date