# WAUCONDA PHYSICAL THERAPY
# PATIENT REGISTRATION

## PATIENT INFORMATION

Name:_____DOB:_____SS #:_____
(First) (Middle Initial) (Last)

Street:_____ Home Phone: _____

City:_____State:____Zip:_____ Cell Phone: _____

(Please circle your preferred form of communication) Email: _____

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**