PERFORMANCE PT
physical therapy + sports training

NEW PATIENT REGISTRATION

ASSIGNED TO: _____

PLEASE PRINT

APPT. DATE
/ /

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH / /	SOCIAL SECURITY NUMBER	SEX

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ( )

MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )	HAVE YOU BEEN TREATED BY THIS OR ANY OTHER PHYSICAL THERAPY CLINIC BEFORE? PLEASE NAME.

EMPLOYMENT STATUS EMPLOYED ( ) FULL TIME STUDENT ( ) PART TIME STUDENT ( ) N/A ( )	EMPLOYER NAME / SCHOOL NAME	TITLE / POSITION

WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ( )

E-MAIL ADDRESS	CELL PHONE ( )

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE ( )

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST NAME	MI

ADDRESS	STATE	ZIP CODE

HOME PHONE	WORK PHONE

RELATIONSHIP SPOUSE ( ) PARENT ( ) GUARDIAN ( ) FRIEND ( )	PARENT OR GUARDIAN E-MAIL ADDRESS

REASON FOR TODAY'S VISIT

IS THIS INJURY / CONDITION RELATED TO YOUR ...

JOB: YES ( ) NO ( )	CAR: YES ( ) NO ( )	HOME: YES ( ) NO ( )	OTHER ACCIDENT: YES ( ) NO ( )

PLEASE INDICATE THE DATE OF ACCIDENT OR INJURY: / /	PLEASE INDICATE THE DATE OF ILLNESS (1ST SYMPTOM) / /

PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT:	TELEPHONE:

PLEASE DESCRIBE INJURY / ACCIDENT / ILLNESS:

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

	RESPONSIBLE PARTY SIGNATURE X	TODAY'S DATE / /	

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER		GROUP NUMBER
ADDRESS	CITY	STATE	ZIP CODE	PHONE
POLICYHOLDER (if other than patient)		SEX	DATE OF BIRTH	
SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)		RELATIONSHIP TO PATIENT	
EMPLOYER (of policyholder)				

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME		IDENTIFICATION NUMBER		GROUP NUMBER
ADDRESS	CITY	STATE	ZIP CODE	PHONE
POLICYHOLDER (if other than patient)		SEX	DATE OF BIRTH	
SOCIAL SECURITY NUMBER (of policyholder)	PHONE NUMBER (of policyholder)		RELATIONSHIP TO PATIENT	
EMPLOYER (of policyholder)				

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO PERFORMANCE PHYSICAL THERAPY AND SPORTS TRAINING IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT OWING AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER THIRTY DAYS OLD. IF REIMBURSEMENT IS MADE BY OTHER PAYER SOURCES, I.E. ATTORNEYS, ATTORNEY LIENS, OR THIRD PARTY INSURANCES, NEGOTIATED INSURANCE DISCOUNTS WILL NOT APPLY. PAYMENT IN FULL PER THE CLINIC'S FEE SCHEDULE IS EXPECTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF PERFORMANCE PHYSICAL THERAPY AND SPORTS TRAINING AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE: X	TODAY'S DATE: / /