VISIONS PHYSICAL THERAPY **NEW PATIENT REGISTRATION**

TODAY'S DATE _____/_____/_____

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SEX	AGE

MAILING ADDRESS	CITY	STATE	ZIP CODE	MARITAL STATUS

CELL PHONE	WORK PHONE	NAME OF EMPLOYER	EMPLOYED	STUDENT

SOCIAL SECURITY NUMBER	EMPLOYER ADDRESS

PROVIDE THE INFORMATION OF THE PERSON WHOSE NAME IS ON THE INSURANCE CARD.
IF IT IS THE SAME AS THE PATIENT, PLEASE PROVIDE AN EMERGENCY CONTACT.

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	AGE	PHONE

MAILING ADDRESS	CITY	STATE	ZIP CODE	EMPLOYER	S.S.N.

MEDICAL INFORMATION

REFERRING PHYSICIAN	INJURY DATE	SURGERY DATE	ICD9 CODE:

DIAGNOSIS

EMPLOYMENT RELTED: _____ YES _____ NO: ACCIDENT DETAILS:

AUTO ACCIDENT: _____ YES _____ NO: ACCIDENT DETAILS:

OTHER ACCIDENT: _____ YES _____ NO: ACCIDENT DETAILS:

SCHOOL INJURY: _____ YES _____ NO: ACCIDENT DETAILS:
*IF YOU HAVE SCHOOL INSURANCE PLEASE PROVIDE A SCHOOL INSURANCE FORM TO THE FRONT DESK COMPLETELY FILLED OUT

OFFICE USE ONLY INSURANCE INFORMATION - PLEASE PRESENT CARDS AT FRONT DESK ***OFFICE USE ONLY***

PRIMARY INSURANCE NAME & ADDRESS

IDENTIFICATION #	GROUP #	NAME ON CARD	RELATIONSHIP

COMMENTS/RESTRICTIONS

DED. IN	DED. MET	% OF UCR	DED. OUT	DED. MET	% OF UCR	PRE-CERT?
						AUTHORIZED BY

SECONDARY INSURANCE NAME & ADDRESS	PHONE

IDENTIFICATION #	GROUP #	NAME ON CARD	RELATIONSHIP

COMMENTS/RESTRICTIONS

DED. IN	DED. MET	% OF UCR	DED. OUT	DED. MET	% OF UCR	PRE-CERT?
						AUTHORIZED BY

WORKER'S COMPENSATION - NAME OF EMPLOYER, ADDRESS, CITY, STATE, ZIP OR CASUALTY/LIEN ACCOUNT

CONTACT PERSON	BENEFITS APPROVED/DENIED	LIEN LETTER?	ATTORNEY YES NO	PHONE

W/C INSURANCE COMPANY - NAME, ADDRESS, CITY, STATE, ZIP	PHONE

ADJUSTER	REHAB NURSE	BENEFITS APPROVED/DENIED	CLAIM #

ATTORNEY NAME & ADDRESS	PHONE

COMMENTS/RESTRICTIONS	THERAPIST

(OVER)

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment to the physician who referred me for treatment, as well as any organization responsible for payment of my account. I also authorize my referring physician if any to release to VISIONS PHYSICAL THERAPY, LLC any and all medical or other information pertinent to my treatment.

MEDICARE

I certify that the information given by me in applying for payment under titlexvii of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request the payment of authorized benefitsbe made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

GUARANTEE PAYMENTS

In consideration of services rendered to me by VISIONS PHYSICAL THERAPY LLC, I hereby guarantee payment for any and all services rendered to me, which are not covered or allowable by insurrance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation and further agree to pay interest or a monthly services charge on all such amount not paid when due at the rate of 1.5% per month, (18% APR). I understand that the patient responsibility portion of my bill will be due and payable at time of service.

PRIVATE INSURANCE

As a courtesy, private insurance will be billed for you one time only during your treatment period in the event that payment is not received in a timely manner, for any reason, you will be responsible for the full balance and will need to contact your insurance carrier directly.

APPOINTMENTS

I understand that my appointment will be the time reserved exclusively for me and is not available for anyone else. Should I find it impossible to keep my appointment, I will notify your office within 24 hours prior to my appointment. I understand that failure to do so results in a $25.00 charge for this missed appointment.

ASSIGNMENT OF BENEFITS

I authorize that Medicare, Medicaid, or any third party sources make the payment, of authorized payments directly to VISIONS PHYSICAL THERAPY LLC for any services that are reimbursable.

CONSENT OF TREATMENT

I hereby consent to such treatment proceudres and patient care, which in the judgment of my physician may be considered necessary or advisable while a patient at VISIONS PHYSICAL THERAPY LLC.

A COPY OF THIS MAY BE CONSIDERED AN ORIGINAL FOR INSURANCE PURPOSES

Signature of Patient/Insured	Patient's Agent or Representative
Witnessed By	Date