REGISTRATION FORM

Please hand insurance card and ID to receptionist and Please print

Today's Date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Mr. Mrs.	Miss Ms.	Marital status: Single Mar Div Sep Wid

Is this your legal name? Yes No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: M F

Street address/ P.O Box:	Social Security #:	Home phone #: ( )

City:	State:	Zip:	Cell #: ( )

Occupation:	Employer:	Employer phone # ( )

How did you find us? (Please check one) ☐ MD ☐ Internet ☐ Insurance plan ☐ Work

☐ Family ☐ Friend ☐ Close to home/ work ☐ Yellow Pgs ☐ Other

REFERRING MD

FOR OFFICE USE

NAME:	Phone:	Fax:

INSURANCE /BENEFITS INFORMATION

FOR OFFICE USE

Insurance:	ID# :	Ins Phone #:
Co-Pay:	Effective Date:	
Deductible:	Deductible Met/ Not Met:	
Max number visits:	Visits to date:	Max $ Amount:
Pre authorization Required YES/NO	Referral Required: YES/NO	
Authorization#:	Visits Auth'd:	Valid:
Comments:		
Comments:	By Ins. Rep Name:	
Secondary Ins:	ID:	

IN CASE OF EMERGENCY

Name of local friend/Relative:	Relationship:	Phone #:	Work phone#:

The above information is true to the best of my knowledge. I hereby assign all medical benefits for which I am entitled to South Mountain Physical Therapy, LLC in the event they file insurance claims on my behalf. I understand that I am responsible for all charges whether paid or not by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount and understand a 30 % addition to defaulted amount will be charged to cover collection fees. Interest may be charged in the amount of 1% per month (12% annually) for unpaid balances over 60 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be as considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of South Mountain Physical Therapy, LLC 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 except in acts of negligence.

Patient/Guardian signature: **Date:**