

**TWIN RIVERS PHYSICAL THERAPY, PC**  
**PATIENT REGISTRATION**  
**(Minor)**

**Acct#** \_\_\_\_\_

Today's

Date: \_\_\_\_\_

Referring Dr: \_\_\_\_\_

SCRIPT: \_\_\_\_\_ YES \_\_\_\_\_ NO

Date of Rx: \_\_\_\_\_

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_

(Last)

(First)

(Mi)

CELL PHONE \_\_\_\_\_

PATIENT ADDRESS \_\_\_\_\_

(Street)

(City)

(ST)

(Zip)

SEX \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ PATIENT E-MAIL ADDRESS \_\_\_\_\_

NAME OF PARENT/GUARDIAN \_\_\_\_\_

ADDRESS (If different than above) \_\_\_\_\_

PARENT/ GUARDIAN DOB \_\_\_\_\_ PARENT/ GUARDIAN SS# \_\_\_\_\_

PARENT/ GUARDIAN EMPLOYER \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ADDRESS \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS/PHONE \_\_\_\_\_

FAMILY DOCTOR (name and city) \_\_\_\_\_

**Due to a new confidentiality policy:**

May we fax records/progress notes to your referring Dr.? \_\_\_\_\_ yes \_\_\_\_\_ no

Also please fax/send copies of my records to the following Drs: \_\_\_\_\_

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**Please check all acceptable contact options:** Call your home # and/or cell# and leave a message \_\_\_\_\_  
leave a message with your spouse/child \_\_\_\_\_ Call your work # and leave a message on your voice mail \_\_\_\_\_  
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**(OVER)**

**A COPY OF INSURANCE CARD(S) IS REQUIRED FOR PROCESSING OF ALL CLAIMS, UNLESS WORKER'S COMP.**

INSURANCE CARRIER #1 \_\_\_\_\_

ADDRESS \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

INSURANCE CARRIER #2 \_\_\_\_\_

ADDRESS \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

**CANCELLATION POLICY:** We understand that circumstances arise that make it necessary to cancel your appointment on short notice. A 24 hour notice is appreciated for cancellation of an appointment whenever possible so the time slot may be utilized for other patients. Two (2) or more cancellations/no shows without 24 hour notice will be subject to a \$25 service fee that is not billable to your insurance company. Thank you for your cooperation in this matter.

**AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION:** I consent to the provision of care rendered by therapists of Twin Rivers Physical Therapy, PC (TRPT). I authorize TRPT and any therapist who treats me/the patient, to release to its authorized billing agents or billing agents of any of the third party payor, or any other intermediaries responsible for payment of my/the patient's charges the following information: diagnosis and other necessary medical information via fax or other methods. I authorize provision of information concerning my care, condition and treatment for quality assurance/risk management purposes.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize release of medical information necessary to process my Medicare/insurance claim and assign benefits directly to Twin Rivers Physical Therapy, PC. I understand I am responsible for charges not covered by this assignment.

**FINANCIAL AGREEMENT:** It is understood, whether I sign as agent, or as patient, or as 'Guarantor' that I am directly responsible and will pay for services rendered and not paid by insurance. I further understand a 1.5% service charge will accrue on any unpaid balance on my account. Should the account be referred to collection, I (patient, agent and 'Guarantor') shall pay reasonable costs of collection including but not limited to attorney's fees and court costs incurred as a result of any suit or claim that may be filed in connection therewith.

**I have read this form and understand its contents. I have had an opportunity to ask questions which have been answered to my satisfaction. A copy of TRPT Financial Policy is available upon request.**

\_\_\_\_\_ **I would like a copy of the HIPAA Notice of Privacy Practices and Consent form I have signed.**

\_\_\_\_\_ **I would not like a copy of the HIPAA Notice of Privacy Practices and Consent form I have signed.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_