

PERFORMANCE PHYSICAL THERAPY

Patient Registration

Please Print Clearly

Patient Name: _____ Birth Date: _____ Gender: M F
Last First MI

Address: _____
Street/PO Box Apt # City State Zip+4

Employer: _____ Social Security # _____ - _____ - _____

Phone: () _____ Cell phone: () _____ Work Phone: () _____

Appointment Reminders: Our office does not make Appointment Reminder telephone calls. However you may choose to receive Appointment Reminders by text message or by email. Please indicate one choice below:

- Text message reminder to the above cell phone number. My cell phone carrier is : _____
I recognize that normal text messaging rates may apply.
- Email reminder to this email address: _____

Parent (if **minor** or **college student**)/Responsible Party Name: _____ Date of birth _____

Address: _____ Phone () _____
Street City State Zip

REASON FOR VISIT/Area of body to be treated: _____ Date of onset: _____ Date of surgery: _____

Primary Physician: _____ Referring Physician: _____

HEALTH INSURANCE INFORMATION

Primary Insurance: _____ Subscriber's Name: _____ Subscriber's Birth date _____

Consumer/Subscriber# _____ Group Plan # _____ Co Pay _____

Secondary Insurance: _____ Subscriber's Name: _____ Subscriber's Birth date _____

Consumer/Subscriber# _____ Group Plan # _____

ACCIDENT INFORMATION

MOTOR VEHICLE ACCIDENT, Date of injury: _____

In Washington State? Yes No If No, where? _____

PIP Insurance: _____

Claim #: _____

PIP Adjuster: _____

Phone: _____

If you have consulted an attorney, please provide:

Attorney Name: _____

Phone #: _____

WORK RELATED INJURY, Date of injury: _____

Employer at time of injury: _____

Have you received previous Physical Therapy for this claim?

Yes No If yes, where? _____

Washington State L&I Claim #: _____

If self-insured Workman's Comp,

Name of Company: _____

Address: _____

Phone #: _____

Adjuster: _____

Please sign CONSENT and RELEASE on Reverse

Staff _____

Eval Date _____

Therapist _____

Revised 12/13

Consent to Treat and Authorization to Bill Insurance

I consent to treatments and authorize use of this signature for the release of medical information necessary to process all claims with my insurance company. Performance Physical Therapy (PPT) will bill my insurance company directly and I authorize direct payment of benefits to PPT. I understand it is my responsibility to know my healthcare benefits, its limits and non-covered items. I will keep Performance Physical Therapy informed of any changes to my insurance coverage. I will be personally responsible for any copays, deductible, or non-covered balances remaining after insurance consideration. I understand that my insurance requires that copays are made at the time of each visit.

If I choose to receive Appointment Reminders by text messaging, normal text messaging rates may apply.

I also understand that any email communication that I may agree to receive is not sent in an encrypted format.

Date: _____

Signature of Patient or responsible party (if patient is a minor)

"NOTICE OF PRIVACY PRACTICES"

Law requires us to make a good faith effort to obtain your signature signifying you have been offered a copy of our Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. The Notice provides a description of our treatment, payment, healthcare operations, and the uses and disclosures we may make of your Protected Health Information. It explains in detail the procedures we use to protect your healthcare and personal information. Please take the time to read it carefully and completely.

"By my signature below I acknowledge receipt of the Notice of Privacy Practices. I also understand that I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations."

Patient or legally authorized individual signature

Date

Time

MEDICARE PATIENTS: PLEASE COMPLETE THIS SECTION

LIFETIME AUTHORIZATION

Provider: Performance Physical Therapy, Inc.
2075 Barkley Blvd, Suite 200, Bellingham, WA 98226 **OR**
1616 Cornwall Ave, Bellingham, WA 98225

Patient's Name: _____

Patient's Medicare #: _____

Patient's Address: _____

This authorization is good until revoked/rescinded by patient.

I request that payment under the medical insurance program be made to the provider named above on any bills for services furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Date: _____

Patient's Signature: _____

