PERFORMANCE PHYSICAL THERAPY, Inc., P.S.

*Please **Print** Clearly*

Patient Registration

Patient Name: ____ Birth Date: _______________ Gender: M F
Last First MI

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

Employer: ___________________________________ Email: ____

Phone: ( ) ________________ Cell phone: ( ) __________________ Work Phone: ( ) _________________

☐ I would like to receive email communication to stay up to date with Performance Physical Therapy and local events.

How did you hear about us?

- ☐ Doctor recommendation
- ☐ Other practitioner (chiropractor, etc.)
- ☐ Friend or Family
- ☐ Other: _______________________

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 Provider**: ________________________________

HEALTH INSURANCE INFORMATION – Please fill out **completely** for billing confirmation

Primary Insurance: _____________________ Subscriber's Name: _______________________ Subscriber's Birth date _______

Consumer/Subscriber# _____________________ Group Plan # ______________

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

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 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

MEDICARE PATIENTS: PLEASE COMPLETE THIS SECTION

LIFETIME AUTHORIZATION

Provider: Performance Physical Therapy
1616 Cornwall Ave, Suite B, Bellingham, WA 98225

Patient's Name: ____

Patient's Medicare #: ____

Patient's Address: ____

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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.

Date: _____________________ Patient's Signature: ____