REGISTRATION FORM

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State _____ Zip _____

Phone Number: _____ Cell #: _____ Emergency #: _____

Social Security Number: _____ Single Married Divorced Widow Child Other

Employer: _____ Occupation: _____

Employer Address: _____ Work Number: _____

Spouse/ Employer/ Phone Number: _____

How did you hear about our facility? _____

If friend or relative, who should we thank? _____

MEDICAL HISTORY

Height: _____ Weight: _____ Current Medications: _____

Medical Physician: _____

Current Injury: _____ Result of Accident? _____ Work Related? _____ Date of Injury _____

Please Check All That Apply: Heart Disease ___ Stroke ___ Pacemaker ___ Respiratory Disease _____

Pregnant ___ Seizures ___ Infectious Disease ___ Diabetes ___ Other : _____

This year have you received: Physical Therapy _____ Chiropractic _____ Speech _____ Occupational _____

Any Home Health Care _____ Where and When? _____

As a courtesy to all our patients, we will submit your insurance forms directly. You are responsible for obtaining any necessary referrals or prior authorization from your physician or health plan. Copays are due at the time of service unless other arrangements are made.

I hereby assign all medical benefits to be paid directly to Therapy Works. I authorize the disclosure of records and any information necessary to process my claim to my insurance carrier, lawyer, or referring physician. I also authorize medical records to be released to Therapy Works. I understand that payment is my responsibility; any portion not paid by my insurance company will be paid in a timely manner. If payments are not made, Therapy Works reserves the right to charge a 1-1/2% interest per month (18% annum) and institute any necessary collection procedures. IF YOUR ACCOUNT GOES INTO COLLECTION, THERE WILL BE AN ADDITIONAL $50.00 FEE.

Acknowledgement of Notice of Privacy Practices

_____ _____

In Acknowledgement Date