

Physical Therapy Registration

Date: _____

How did you hear about us? _____

Patient Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Birth Date: _____ Age: ___ Sex: M F Email Address: _____

Date of Injury: _____ Employer: _____

Referring Physician: _____ General Physician: _____

Emergency Contact: _____

Name

Phone

Insurance – Please present your card to the receptionist

Who is person responsible for this account?

Name Relationship Address Phone #

Workers Compensation #: _____

Auto Insurance:

Claim Number: _____ Insurance Company Name: _____

Address: _____

This document summarizes the agreement between Wind City Physical Therapy and each patient who accepts treatment.

1. Consent for medical treatment

I understand and acknowledge that I am presenting myself voluntarily for outpatient physical therapy treatment. I authorize and consent to this treatment.

2. Financial agreement

By accepting the physical therapy services provided to me as an outpatient, I agree to be financially responsible for the charges billed by Wind City Physical Therapy for those services.

I understand that any co-payment required by my insurance company is due at each treatment session.

I hereby assign insurance benefits to Wind City Physical Therapy and authorize my insurance company to directly pay Wind City Physical Therapy.

I understand that I am responsible for unpaid insurance balances. I will also be responsible for any reasonable collections or attorney fees incurred by Wind City Physical Therapy related to costs of turning my account over for collection.

3. Release of medical information

I authorize the release of necessary information to my insurance company, employer, physician, and/or third party payers.

4. Privacy practices

I have received a copy of Wind City Physical Therapy privacy practices

5. Policy regarding missed or cancelled appointments

In order to accommodate other patients who may be waiting for treatment, we require 24 hours notice if your appointment must be cancelled. We reserve the right to charge a \$50.00 fee for appointments that are not kept or cancelled within 24 hours. Three missed appointments without notice will result in a discharge from physical therapy.

6. I have read this document and understand its content.

Patient or _____
Legal Guardian – relationship Date

Request for Release of Information

Patient's Name: _____ Birth Date: _____
Address: _____

I authorize Wind City Physical Therapy to receive my medical records from:

Casper Medical Imaging	XRAY	CT SCAN	fax #: 577-0443
Central Wyoming Imaging	XRAY	MRI	fax #: 266-0985
Wyoming Imaging Center	MRI		fax #: 577-0072
WMC Radiology	XRAY	CT SCAN	fax #: 577-2888

Purpose for release: ASSIST IN PHYSICAL TEHRAPY TREATMENT

Patient Signature (legal guardian)

Date

*This release will expire 1 year from date signed.

** This release may be revoked at anytime