



## PATIENT INSURANCE/REGISTRATION FORM

Patient's Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

*(If your mailing address is a P.O. Box - Please list street address along with the P O Box)*

Phone #: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Patient's Employer and Occupation: \_\_\_\_\_

Marital Status/Partner's Name, Employer and Occupation: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

### **Nearest Friend or Relative not living with you in case of an emergency:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

### **RESPONSIBLE PARTY: (If different from above)**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

### **INSURED INFORMATION: PRIMARY**

**Is your condition related to an auto accident? \_\_\_ Date of injury: \_\_\_\_\_**

**Is your condition related to a workman's comp injury? \_\_\_ Date of injury: \_\_\_\_\_**

**Claim #: \_\_\_\_\_ Name of claim's manager: \_\_\_\_\_**

Insurance and Name of Subscriber: \_\_\_\_\_

Relationship to patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Subscribers DOB: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Send Claims to Address: \_\_\_\_\_

### **INSURED INFORMATION: SECONDARY**

Insurance and Name of Subscriber: \_\_\_\_\_

Relationship to patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Child \_\_\_\_\_ Other \_\_\_\_\_

Subscribers DOB: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Send Claims to Address: \_\_\_\_\_



Who referred you to this office? \_\_\_\_\_

Please list other health care providers that might be relevant to your treatment.

(This office will not contact these individuals unless you sign a release of information).

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Please list any medication you are currently taking:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**Please read the following:**

**It is my responsibility:**

- to pay the deductible, co-insurance or any other balance not paid by my insurance. Balances over 90 days will be sent to collections.
- to determine if Tensegrity Physical Therapy is a provider for my insurance.
- to keep track of my total number of visits. If my visit limit is exceeded I am responsible for billed amount.
- to cancel my appointment before 5pm of the day preceding my appt to avoid a \$75.00 cancellation fee. This fee also applies to no-shows.
- to give proper insurance information and update Tensegrity Physical Therapy with any changes.
- to inform Tensegrity Physical Therapy of claims that are related to a workman's compensation injury or motor vehicle accidents prior to any treatment. I understand Tensegrity Physical Therapy cannot retro-actively bill any claims that were previously billed to personal insurance and it will be my responsibility to pay for any claims that are denied because of this.
- to have a prescription from my primary care physician for treatment if required by insurance.

Patient's or authorized person's signature: I authorize the release of my medical or other information necessary to process this claim. I also request payment of government benefits, private insurance and other health plans to the party who accepts assignment below.

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to a reasonable attorney's fees and cost of collections.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my records.

I hereby assign all medical and/or mental health benefits to include major medical benefits to which I am entitled, including private insurance and other health plans, to Tensegrity Physical Therapy.

This assignment will remain in effect until revoked by me, in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_