ABSOLUTE
PHYSICAL THERAPY & FITNESS

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Patient Express Registration Form

_____ _____ _____ _____/_____/_____ M /F
Patient First Name | Patient Last Name | MI | Date of Birth

_____ _____ _____ PT / FT Student
Mailing Address | Apt # | City | Zip

(_____)_____ (_____)_____ _____ Sinlge / Married
Main Contact # | Secondary Contact # | Email

_____-_____-_____ _____ (_____)_____
Social Security # | Emergency Contact Person | Emergency Contact #

IF THE PATIENT IS A MINOR (UNDER 18): I hereby give my consent for the therapist(s) and/or staff of Absolute Physical Therapy to evaluate and administer physical Therapy treatments as recommended for the minor child listed above.

_____ _____ _____
Signature of Parent or Legal Guardian | Parent or Legal Guardian Name | Relationship to Minor

_____ (_____)_____ _____ (_____)_____
Primary Care Physician | Phone # | Referring Physician | Phone #

Whom may we thank for telling you about our facility? _____

MY CONDITION IS RELATED TO: ___WORK ___AUTO ACCIDENT (State:_____) OTHER:_____

CURRENT WORK STATUS: ____FT ___PT ___LIMITED DUTY (RESTRICTIONS:_) ___DISABLED (TOTAL / TEMP) ___RETIRED

_____ _____ (_____)_____
Occupation | Employer | Phone #

I INTEND TO PAY FOR MY SERVICES TODAY BY THE FOLLOWING METHOD (PLEASE CHECK ONLY ONE BOX):

(A) ___I HAVE INSURANCE (Please provide copy of front and back on insurance card). I understand it is my responsibility to know and understand my benefits and I must pay the deductible/coinsurance/copay before each visit. If my insurance pays differently than quoted or denies services, I have a legal obligation to make payment in full. If my insurance changes I will give you the new information at that time or the responsibility for payment becomes my own.

_____ _____ _____ _____
Primary Insurance | ID # | Group # | Name of Insured

_____ _____ _____ _____
Secondary Insurance | ID # | Group # | Name of Insured

***Please inform the front desk immediately if you are currently receiving or have received any form of home health care in the past 3 months. Your Insurance may DENY PAYMENT for outpatient therapy services if also receiving home health. YOU WILL BE RESPONSIBLE FOR ANY CHARGES DENIED BY YOUR INSURANCE.**

(B) ____I HAVE AN ATTORNEY and would like to :
____Get a 30% discount by paying up front. I'll get reimbursed after my case settles.
____Wait until my case settles before paying. I will complete the "Attorney Lien" Form.

(C) ___ Self Pay. I will set up a treatment program and pay for the services as set out in the package.

I have been given the opportunity to review the Privacy Notice for Absolute Physical Therapy and given the opportunity to obtain a copy for myself. I understand my rights as contained in the Privacy Notice.

By way of my signature, I provide Absolute Physical Therapy with my authorization and consent to use and disclose my protected healthcare information for the purposes of treatment, payment and health care operations as described in the privacy notice.

_____ _____ _____/_____/_____
Patient or Authorized Signature | Authorized Facility Signature | Todays Date