SHERMAN PHYSICAL THERAPY
PATIENT REGISTRATION FORM

Patient Legal Name:		
Last:	**First:**	**Middle Initial:**

Referring Physician: _____Primary Care Physician: _____

Diagnosis: _____Date of Birth: _____Sex: M ☐ F ☐

Mailing Address: _____

Phone Number: _____Cell Phone Number: _____

Work Number: _____ Social Security Number: _____

Motor Vehicle Claim (in the last 2 years)? ☐ Yes ☐ No		
Labor & Industries Claim (in last 2 years)? ☐ Yes ☐ No		
If L&I, Employer's Name & Address:	Employer's Phone Number:	
Is your visit today related to a motor vehicle accident or L&I claim? ☐ Yes ☐ No		

Billing Information

Bill me, I will pay when billed: Yes No

Or, bill my insurance company(s) _____ (Please provide information below).

Insurance Co:	Primary	Secondary
Name:	_____	_____
Plan Name:	_____	_____
Subscriber:	_____	_____
Subscriber's DOB:	_____/_____/_____	
Relation:	_____	_____
Policy #:	_____	Group #:_____

Emergency Contacts:

1.) Name:_____Phone Number_____
2.) Name:_____Phone Number_____

SHERMAN GENERAL CONSENT

I, the undersigned patient or patient's representative, request admission to SHERMAN PHYSICAL THERAPY for care and treatment. I certify that the information given is correct. I am aware that the practice of physical therapy is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment or examination. I consent to and authorize the following:

RELEASE OF MEDICAL INFORMATION: I authorize SHERMAN PHYSICAL THERAPY to release any information necessary to my insurance company to facilitate health care processing of claims, and audit of payments relative to this care. I also consent to the release of any information as needed to my referring physician and to other health facilities or agencies as I direct or as required by law.

FINANCIAL AGREEMENT: I certify that the information given in applying for payment under government or private insurance is correct. I understand that any insurance benefit information given to me by any representative of SHERMAN PHYSICAL THERAPY is based on general information they have received from the insurance carrier and may not specifically address my benefit package. **I understand that it is my responsibility to know my specific benefits.** I understand that I am financially responsible to SHERMAN PHYSICAL THERAPY for charges not covered by my insurance carrier. **SHERMAN PHYSICAL THERAPY will bill my primary insurance and my secondary insurance. If insurance does not pay, I understand the amount due is my responsibility.** SHERMAN PHYSICAL THERAPY reserves the right to impose reasonable financing and late charges as well as reasonable cost, attorney fees and expenses incurred in the collection of my account should it become delinquent.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment directly to SHERMAN PHYSICAL THERAPY, including major medical insurance coverage.

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. (Consent applies only when applicable.)

Patient or other legally responsible person's signature Date

_____

Relationship of legally responsible person to patient