Patient Registration Form:

Family Care Plus Physical Therapy & Wellness
Specialized Orthopedic and Spine Physical Therapy

(Type last name,first name, initial, DOB: dd/mm/yyyy. Office use)

Name: _____ DOB: _____
(Last Name) (First Name) (Middle Name) *(Date/Month/Year)*

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

Home Phone: _____ Cellphone/Other Phone: _____

Social Security Number: _____ Emergency Contact Person: _____

Phone Number Of The Contact Person: _____ & Relationship: _____

Employer: _____ Work Phone: _____

Referring Doctor: _____ Primary Care Doctor: _____

Person Responsible For the Medical Bills: _____ Phone #: _____

INSURANCE INFORMATION: *(Please Provide Insurance Card To Receptionist)*

Primary Insurance: _____ Secondary Insurance: _____

Subscriber Name: _____ Relationship To The Subscriber: _____

Policy Number: _____ Group Number: _____

***For Auto Injuries/Work Injury Claims Or Other Litigation/Compensation, Please Provide The Following Information:**

Insurance Name: _____ Adjuster/Claim Manager: _____

Contact Phone Number: _____ Claim Number: _____

*Feel free to provide us with a copy of the documents necessary for processing this claim. *See Attached Papers: ☐

FOR MEDICARE PATIENTS ONLY: **Check Here If Not A Medicare Patient:** ☐

Received Out-Patient Physical Therapy/Speech Therapy Services This Calendar Year? YES _____

If yes, has your Medicare Services Cap been met? : _____

Consent for Physical Therapy Services: *I hereby give consent to the professional staff at Family Care Plus Physical Therapy & Wellness, LLC to deliver required physical therapy care for my condition. Such care may include: Physical Therapy evaluation procedures, therapeutic exercises, patient education, and specialized techniques including manual therapy as well as modalities as needed. I understand that I have the rights to refuse any of the treatments offered.*

I authorize my insurance benefits be paid directly to Family Care Plus Physical Therapy & Wellness, LLC. I understand that I am financially responsible for any balances, co-pays, deductibles, and so on required as per my insurance provider. I also authorize Family Care Plus Physical Therapy & Wellness, LLC or my insurance company to release any information required to process my claims. In addition, I hereby authorize release of Medical Records required for my therapy needs to Family Care Plus Physical Therapy & Wellness, LLC. I acknowledge that I was provided a copy of the Notice of Privacy Practices at Family Care Plus Physical Therapy & Wellness, LLC and that I have read (or had the opportunity to read if I so choose) and understand the Notice. The above information is true to the best of my knowledge.

Patient Signature/Guardian Signature: _____ Date: _____