SPAGNOLI PHYSICAL THERAPY

REGISTRATION INFORMATION

EMAIL:_____

PLEASE PRINT

DATE_____ Home Phone_____ Cell Phone_____

Patient_____

Last name First name initial

Responsible Party (if Minor)_____

Street Address_____

City_____ State_____ Zip_____

My current gender identity is: _____My sex assigned at birth is: _____

My pronouns are: _____

Age_____ Birthdate_____ Employed: Y or N Student: FT or PT

Patient Employed by_____

Business Address_____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____ Birthdate_____

Who is responsible for this account?_____ Relation to insured?_____

Social Security #_____

Do you have medical insurance? Yes or No If yes,

Name of Primary Insurer Carrier_____

ID#_____ Group#_____ Phone #_____

Name of Secondary Insurer Carrier_____

ID#_____ Group#_____ Phone #_____

Who Referred You to This Office?_____

PLEASE TURN OVER

ASSIGNMENT AND RELEASE

INSURANCE AND/OR MEDICARE AUTHORIZATION

I request that payment of authorized Insurance benefits be made either to me or on my behalf to SPAGNOLI PHYSICAL THERAPY for any services furnished to me by that office. I authorize any hold of medical information about me to release to my Insurance Company, Health Care Financing Administration and/or its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency show. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare/Insurance carrier

Patient Signature Date

Per New York State law, I understand that it is my responsibility to provide an up to date prescription from my referring physician, thus I will not be seen for physical therapy with an out of date prescription.

Patient Signature **Date**

CANCELLATION AND NO-SHOW POLICY

Our policy requires that you give 24 hours notice for all appointment cancellations. This policy is in place to maximize your progress, and minimize loss of appointment slots for other patients. Cancellations with less than 24 hours notice and "No-Shows" for scheduled appointments will be subject to a $25.00 fee. This is NOT covered by your insurance company.

Patient Signature **Date**

I have read the ***The Notice of Privacy Practices*** (separate sheet) and am informed of my rights and the practices and legal duties with regard to protected health information. I have also read ***Patients's Bill of Rights*** and am informed of my rights as a patient.

Patient Signature **Date**