SOUTH CITY PHYSICAL THERAPY

443 Grand Avenue
South San Francisco, CA 94080
(P)650-588-9668
(F)650-588-3230

PATIENT REGISTRATION FORM

Date:

Patient's name: M or F Date of birth:

Patient's address: Street SS no:

City, State, Zip Home phone:

Employer: ☐ Unemployed ☐ Retired Work phone:

Work Address: Street Cell phone:

City, State, Zip Physician:

Email address: Physician phone #:

Insured's Information if other than patient:

Name: Date of birth:

Address: Street SS no:

City, State, Zip Home phone:

Employer: ☐ Unemployed ☐ Retired Work phone:

Work Address: Street Relationship:

City, State, Zip

Injury Information

☐ Work related ☐ Other injury

Date of onset: ☐ Auto accident ☐ No specific injury

Date of Surgery: ☐ Third party liability

Primary Ins: Patient's Primary insurance is through:
☐ Self ☐Spouse ☐ Father ☐ Mother ☐ Other

Address: Street ID no:

City, State, Zip Group no:

Other: Phone no:

Secondary Ins: Patient's Secondary insurance is through:
☐ Self ☐Spouse ☐ Father ☐ Mother ☐ Other

Address: Street ID no:

City, State, Zip Group no:

Other: Phone no:

Contact in Case of Emergency

Name: Phone no:

Address: Street Relationship

City, State, Zip

Patient Registration Form pub

For office use only PTPN? Yes No

PAYMENT POLICY: Payment is due at the time of service. We will accept cash, personal check, Visa, MasterCard, and Discovery Cards. As a courtesy, South City Physical Therapy will bill your insurance carrier for services rendered. You are responsible for all co-payments, your deductible and any amounts determined by your insurance plan, as not deemed medically necessary. Co-payments and any amounts estimated by the staff at South City Physical Therapy to be non-covedred by your insurance company are to be paid at the time of service. Patients should remember that services rendered by our staff are rendered to the patient and not to the insurance carrier. The patient is responsible for payment of all charges. Any outstanding charges will be billed to you on a monthly basis. Payment in full is expected within thirty days of billing. A handling charge may be added to accounts over thirty days. **I have provided current and correct insurance information.**

We value you, our patient, and will continue to provide you with the best physical therapy possible. Should you have any questions regarding the above Payment Policy, please contact our Billing Service.

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Patient, Insured, or Authorized Agent's Signature

CONSENT FOR TREATMENT: I consent to have the staff at South City Physical Therapy provide the treatment and care recommended by my physician(s). I understand this consent may be revoked by me at any time.

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Patient, Insured, or Authorized Agent's Signature

ASSIGNMENT OF MEDICAL BENEFITS: I hereby authorize payment of medical benefits to South City Physical Therapy for medical services rendered.

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Patient, Insured, or Authorized Agent's Signature

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION: I hereby authorize the release of any medical records and information, including statements of my account pertinent to this injury or illness, which are necessary to process this claim.

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Patient, Insured, or Authorized Agent's Signature

BROKEN APPOINTMENT POLICY: I agree to notify South City Physical Therapy with adequate notice for any appointment that I want to cancel. **Adequate advance notice is 24 hours. Inadequate notice will result in a thirty five dollar ($35.00) broken appointment charge.** I understand that insurances do not pay for broken appointment charges and that I will be billed directly for any appointment charge that I incur. I acknowledge the information I have provided is true and correct and fully understand all of the above information.

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Patient, Insured, or Authorized Agent's Signature

_____

Date

_____

Patient's name printed

SOUTH CITY PHYSICAL THERAPY