PATIENT REGISTRATION RECORD

Patient _____ Birthdate _____ Age _____

Address _____ City _____ Zip _____

Marital Status: S M D W SS# _____ - ____ - _____ Phone _____

Employer _____ City _____ BS Phone _____

Spouse's Name _____ Employer _____ BS Phone _____

Patient Cell #: _____ Patient/Parent Email _____

* Alternate Phone: Name/Relation to Patient _____ Phone _____

Family Physician _____ City/Phone _____

IF MINOR: Parent/Legal Guardian Complete the Following:

Name _____ SS# _____ - ____ - _____ Phone _____

Address _____ City _____ Zip _____

Employer _____ City _____ BS Phone _____

INSURANCE INFORMATION

Primary Ins. _____ Ins. Cardholder _____

SS#/ID# _____ Group _____

Secondary Ins. _____ SS#/ID# _____ Group _____

WORKERS' COMPENSATION INFORMATION

Date of Injury _____ Employer at Time of Injury _____

Self-Insured Company's Name _____ Phone _____

Claim # _____

ACCIDENT INFORMATION

Date of Accident _____

YOUR Ins. Co. _____ Address/City _____ Phone _____

Insured Person _____ Adjuster _____ Claim # _____

AT FAULT Ins. _____ Address/City _____ Phone _____

Insured Person _____ Adjuster _____ Claim # _____

YOUR ATTORNEY _____ City/Phone _____

Please Read: Our contract is with you, not your insurance company. PAYMENT ON YOUR ACCOUNT DURING TREATMENT IS EXPECTED WEEKLY. All accounts are due 30 days after first billing. Past due accounts will be assessed late payment charges computed at the rate of 1% per month on the unpaid balance, which is an annual percentage of 12%. In cases of medical liability, the Clinic reserves the right to file paperwork to protect its interest in accordance with WA state law. WE RESERVE THE RIGHT TO CHARGE UP TO YOUR NORMAL APPOINTMENT FEE FOR MISSED APPOINTMENTS.

I authorize direct payment of medical benefits to Puyallup Valley Physical Therapy, Inc., P.S. I authorize release of medical records to designated insurance companies to facilitate said direct payment. Under all circumstances, I agree to final responsibility for my account. I consent to physical therapy procedures prescribed by my physician/physical therapist.

SIGNATURE _____ DATE _____