REACH PHYSICAL THERAPY

Reach Physical Therapy

Committed to helping you reach your goals

REGISTRATION FORM

Today's Date:	EMAIL:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

Address:

Social Security no.:	Home phone no.:	Cell phone no.:
Occupation:	Employer:	Employer phone no.:

How did you hear about us? (Circle one)

Past Patient Walk-In Google Instagram Website

Patient Referral Facebook Advertisement MD

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Primary Insurance:	Secondary Insurance (if applicable):

Subscriber's name:	Birth date:	Do you have Medicare?	Primary Member ID.:	Secondary Member ID:

WORKER'S COMPENSATION/NO FAULT

Insurance Carrier:	Adjuster Name & Contact #:

Claim Number:	WCB Number (if applicable):	Date of Injury/Accident:	Employer (if applicable):	Employer Contact (if applicable):

Additional Information:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Alternate phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider I understand that I am financially responsible for any balance. I also authorize Reach Physical Therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature Date

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MEDICAL HISTORY

Circle all applicable items:				
	High Blood Pressure	Pace Maker/Defibrillator	Stroke	Diabetes
	Lung Disorder	Anemia	Nerve Disorder	Multiple Sclerosis
	Rheumatoid Arthritis	Parkinson's	Joint Dislocation	Metal Implants
	Epilepsy/Seizures	Asthma	Shortness of Breath	History of Cancer
	Past Surgeries	Pregnant	If yes, how many months?	

Current Medications:

HOW CAN WE HELP YOU?

Explain your current symptoms and difficulties:

When did condition(s) start?	Treatment received thus far (medications, injections, chiro, etc.):

GENERAL RELEASE & NOTICE OF PRIVACY PRACTICES

I, _____ hereby agree to have Reach Physical Therapy, PLLC provide the necessary treatment for my diagnosed condition as needed. I authorize my insurance carrier to pay Reach Physical Therapy, PLLC directly for any medical and treatment services provided. Furthermore, I am aware that I am financially responsible for the payment of co-pays, deductibles and balances not covered by Medicare or my Insurance provider at this facility.

If I am the legal guardian of the patient mentioned above, I accept financial responsibility of the above mentioned fees.
I also authorize Reach Physical Therapy, PLLC to obtain any past or current records pertaining to my medical conditions: Accept ○ Decline ○

This medical information may be used by Reach Physical Therapy, PLLC its affiliates, or agents for medical treatment or consultation, billing or claims payment, or other purposes related to my care and reimbursement for my care.

I understand the following in regards to this authorization: The information used or disclosed by Reach Physical Therapy, its affiliate, or agents pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective the extent that any person or entity has already acted in reliance on authorization or authorization was obtained as condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Reach Physical Therapy, PLLC abides by all federal HIPAA laws. Literature on HIPAA available on request.

_____ _____

Patient/Guardian signature Date