One Choice
Physical Therapy, Inc.

Patient Registration Information

Patient Name (Last) _____ (First) _____ (Middle Initial) _____

Street _____ City _____ State _____ Zip _____

Home Tel _____ Cell _____

Date of Birth _____ Marital Status _____

Email: _____ Sex: M_____F _____

Diagnosis _____

Emergency Contact _____Phone: _____

Referring Doctor _____Phone: _____Fax:_____

Insurance Carrier:

Medicare No. _____ Hospital_____Medical _____

Secondary Insurance: **YES** ____ **NO** ____ ID#:_____

Company Name: _____

Insured's Name _____ Date of Birth _____

Release:

I am financially responsible for non-covered services, co-payments and deductibles as assigned by my insurance carrier. I authorize my physician to release to any insurance carrier any information required to process this claim. I will be charged $25.00 for same day (less than 24-hour notice of Cancellation).
Authorization to release information and assignment of benefits: I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, and any other health plan to One Choice Physical Therapy this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an origin. I understand that I am financially responsible for all charges whether paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Assignment:

I hereby assign benefits to be paid directly to One Choice Physical Therapy

Signature _____ Date _____

I have received a copy of One Choice Physical Therapy Privacy Practices

Signature _____ Date _____