Physical Therapy
Doyle & Taylor

NEW PATIENT REGISTRATION

APPT DATE: / /

Please Print PT ☐ OT ☐ ASSIGNED TO:_____

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX
			/ /		

HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE
				( )

MARITAL STATUS	HAVE YOU EVER HAD PHYSICAL THERAPY BEFORE? IF YES, WHERE?
SINGLE ☐ MARRIED ☐ OTHER ☐	

EMPLOYMENT STATUS	EMPLOYER NAME	TITLE/POSITION
EMPLOYED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT ☐ N/A ☐		

WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE
				( )

E-MAIL ADDRESS	CELL PHONE
	( )

REFERRING PHYSICIAN INFORMATION

LAST NAME	FIRST	ADDRESS	PHONE
			( )

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

LAST NAME	FIRST	RELATIONSHIP TO PATIENT	HOME PHONE
		EMERGENCY CONTACT ☐ PARENT ☐ SPOUSE ☐	( )

ADDRESS (CHECK HERE IF SAME AS ABOVE ☐)	CITY	STATE	ZIP CODE	CELL PHONE/WORK PHONE
				( )

REASON FOR TODAY'S VISIT

IS THIS INJURY RELATED TO YOUR…

JOB:	CAR:	HOME:	OTHER:
YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐	YES ☐ NO ☐

PLEASE INDICATE THE DATE OF THE ACCIDENT OR INJURY:	PLEASE INDICATE THE DATE OF THE ILLNESS/FIRST SYMPTOMS:
/ /	/ /

PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT:	PHONE
	( )

PLEASE DESCRIBE INJURY/ACCIDENT/ILLNESS:

RESPONSIBLE PARTY STATEMENT

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE:
X	/ /

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE
				( )

POLICYHOLDER (if other than patient)	SEX	DATE OF BIRTH
		/ /

SOCIAL SECURITY NUMBER (of policyholder)	RELATIONSHIP TO PATIENT	PHONE NUMBER (of policyholder)
		( )

EMPLOYER (of policyholder)

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE	PHONE
				( )

POLICYHOLDER (if other than patient)	SEX	DATE OF BIRTH
		/ /

SOCIAL SECURITY NUMBER (of policyholder)	RELATIONSHIP TO PATIENT	PHONE NUMBER (of policyholder)
		( )

EMPLOYER (of policyholder)

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY ASSIGN ALL MEDICAL BENEFITS TO WHICH I AM ENTITLED TO DOYLE & TAYLOR PHYSICAL THERAPY, LLC IN THE EVENT THEY FILE INSURANCE ON MY BEHALF. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE. IN THE EVENT MY ACCOUNT BECOMES DELINQUENT AND IS THEREFORE IN DEFAULT OF PAYMENT, I ACCEPT RESPONSIBILITY FOR THE PRINCIPAL AMOUNT AS WELL AS ALL REASONABLE COSTS ASSOCIATED WITH THE COLLECTION OF THIS DEBT. THIS INCLUDES BUT IS NOT LIMITED TO COLLECTION SERVICE FEES, ATTORNEY'S FEES, AND ALL COURT COSTS AND ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. INTEREST MAY BE CHARGED AT A RATE OF 1.5% PER MONTH (18% ANNUALLY) FOR UNPAID BALANCES OVER THIRTY DAYS OLD. IF REIMBURSEMENT IS MADE BY OTHER PAYER SOURCES, I.E. ATTORNEYS, ATTORNEY LIENS, OR THIRD PARTY INSURANCES, NEGOTIATED INSURANCE DISCOUNTS WILL NOT APPLY. PAYMENT IN FULL PER THE CLINIC'S FEE SCHEDULE IS EXPECTED. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF THE SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I DO HEREBY CONSENT TO SUCH TREATMENT BY THE AUTHORIZED PERSONNEL OF DOYLE & TAYLOR PHYSICAL THERAPY, LLC AS MAY BE DICTATED BY PRUDENT MEDICAL PRACTICE BY MY ILLNESS, INJURY, OR CONDITION. THIS CONSENT IS INTENDED AS A WAIVER OF LIABILITY FOR SUCH TREATMENT EXCEPTING ACTS OF NEGLIGENCE.

AUTHORIZED SIGNATURE	TODAY'S DATE
	/ /

***** PATIENT COPAYS ARE DUE AT EACH THERAPY VISIT *****