GOIN BEYOND
PHYSICAL THERAPY

PATIENT REGISTRATION

Name: (Last) _____ (First) _____ (MI) _____ (Jr., Sr., etc.) Sex: M or F

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: _____

CONTACT INFORMATION (Check the box next to the best contact number)

□Home phone: _____ □Work Phone: _____ □Cell Phone: _____

Email address: _____

EMERGENCY CONTACT: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____ Date of Birth: _____

Address: (If different from above) _____

City: _____ State: _____ Zip Code: _____ Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ **Insured Name:** _____ **DOB:** _____

Secondary Ins: _____ **Insured Name:** _____ **DOB:** _____

On the job injury? □YES □NO

Worker's Comp Insurance Co. Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Auto Accident? □YES □NO Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? □YES □NO

Have you received, or are you currently receiving Home Health Therapy? □YES □NO

If yes, please provide dates: _____ and the name of Home Health Agency: _____

Have you received, or are you currently receiving Chiropractic Treatment? □YES □NO

I hereby authorize payment of medical benefits to GOIN BEYOND PHYSICAL THERAPY, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

_____ _____

Signature of Patient/Parent or Legal Guardian Date