primetime
PHYSICAL THERAPY

Spine & Sports Rehabilitation • Pilates • Pelvic Health • Lymphedema & Breast Cancer Therapy

Email: care@primetimept.com
www.primetimept.com

PATIENT REGISTRATION

PATIENT'S NAME:_____ PATIENT'S DATE OF BIRTH:_____ PATIENT'S SOC SEC #_____
PATIENT'S GENDER:_____ PATIENT'S MARITAL STATUS:_____ RELIGIOUS BELIIEFS THAT MAY AFFECT CARE? YES / NO
STREET ADDRESS:_____ APT #_____ CITY:_____ STATE:_____ ZIP CODE:_____
MOBILE OR PRIMARY PHONE #:_____ SECONDARY PHONE #:_____
SECONDARY/EMERGENCY CONTACT: NAME:_____ RELATIONSHIP:_____ PHONE #_____
CURRENT EMAIL ADDRESS (FOR APPT. REMINDER NOTIFICATIONS):_____
As a courtesy, you will typically receive a reminder call the day before your appointments. If you do not wish to receive these calls, please check here: ☐

****PLEASE CAREFULLY COMPLETE ALL SECTIONS, AS THIS WILL AFFECT YOUR CLAIM FILING****

INSURANCE INFORMATION

PRIMARY INSURANCE:_____ ID #:_____ GROUP #:_____
SUBSCRIBER'S NAME:_____ SUBSCRIBER'S SOC SEC #:_____ SUBSCRIBER'S D.O.B:_____

SECONDARY INSURANCE:_____ ID #:_____ GROUP #:_____
SUBSCRIBER'S NAME:_____ SUBSCRIBER'S SOC SEC #:_____ SUBSCRIBER'S D.O.B:_____

TERTIARY INSURANCE:_____ ID #:_____ GROUP #:_____
SUBSCRIBER'S NAME:_____ SUBSCRIBER'S SOC SEC #:_____ SUBSCRIBER'S D.O.B:_____

AUTO ACCIDENT OR WORK RELATED INJURY:
AUTO/WORK COMP INSURANCE CO. NAME: _____ CASE WORKER:_____
CLAIM #:_____ ACCIDENT TYPE: _____ DATE OF ACCIDENT: _____ STATE:_____
ATTORNEY'S NAME: _____ ATTORNEY'S PHONE #:_____

MEDICARE PART B PATIENTS: ARE YOU CURRENTLY RECEIVING OR HAVE YOU RECEIVED ANY OF THE FOLLOWING SERVICES **THIS YEAR**?
PLEASE CIRCLE: SPEECH THERAPY, OCCUPATIONAL THERAPY, PHYSICAL THERAPY OR HOME HEALTH.

GUARANTOR INFORMATION (IF DIFFERENT FROM PATIENT)

GUARANTOR'S NAME_____ GUARANTOR'S D.O.B:_____ GUARANTOR'S SS #:_____
STREET ADDRESS:_____ APT #_____ CITY:_____ STATE:_____ ZIP CODE:_____
MOBILE/PRIMARY PHONE #:_____ SECONDARY/WORK PHONE #:_____

ALL PATIENTS AND RESPONSIBLE PARTIES PLEASE READ AND SIGN: I authorize release of any medical information necessary to process the claim. I authorize the payment of medical benefits directly to this office for services rendered. I understand that I am financially responsible for charges not covered by this authorization, except where prohibited by law. If the delinquent account is referred for collection and/or litigation, patient agrees to pay Primetime Physical Therapy's collection agency fees, attorney's fees and court costs associated with the collection/litigation process. I understand that Primetime Physical Therapy assumes no responsibility for personal property such as jewelry, glasses, dentures, clothing items, or any other personal items. I agree to hold Primetime Physical Therapy risk-free from any and all costs, liability and damages of any nature whatsoever, including reasonable attorney's fees, resulting directly from the release of my medical records pursuant to this consent. I acknowledge that I have read this authorization and fully understand its contents.

SIGNATURE:_____ Date:_____
Witness Signature: _____ Date: _____