



Dry Needling • Vertigo • Spine & Sports Rehabilitation • Pediatrics • Pelvic Health • And more!

Email: care@primetimept.com

www.primetimept.com

PATIENT REGISTRATION

NAME: _____ DATE OF BIRTH: _____ SOC SEC #: _____ GENDER IDENTITY: _____
ADDRESS: _____ APT #: _____ CITY: _____ STATE: _____ ZIP CODE: _____
MOBILE PHONE: _____ SECONDARY PHONE/EMERGENCY CONTACT 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 #: _____
GUARANTOR'S 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.

By signing this agreement, I acknowledge that I have read, understand and agree to the above terms and conditions

Patient Signature: _____ Date: _____

Staff/Witness Signature: _____ Date: _____