KINGSLEY PHYSICAL THERAPY

effective direction in healing

NEW PATIENT REGISTRATION

DATE: ___/____/20___

NEW PATIENT REGISTRATION

First Name: _____

Middle Name: _____

Last Name: _____

Nick Name: _____

Social Security No.: _____

Gender: □ Male | □ Female

Date of Birth: _____

Age: _____

Student: Yes (□ full | □ part time) | □ No

Marital Status: □ Single | □ Married

Employer: _____

Address _____

City_____ State _____ Zip_____

Primary Phone Number: _____ □ mobile □ home □ work

Email Address *(for appointment reminders & communication with your therapist)*:

_____

Name of Physician who referred you to Physical Therapy: _____

How will you be paying for your Physical Therapy Services?

□ Self Pay □ Auto Insurance

□ Health Insurance □ Workers Compensation

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring MD, and/or other third party payer. I have read the Notice of Privacy Practices and understand my rights contained in the notice. By way of my signature, I provide Kingsley Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

Treatment of Minors: I, as the parent/guardian of the patient, understand that I have been advised to remain on the premises during that patient's treatment and waive any claim that I may have resulting from failure to do so.

Parent Signature Required _____ Date _____

Patient Signature Required _____ Date _____