

Patient Registration Form

Last Name:		First Name, MI:		Nickname:	
Street:			City:		Zip Code:
Home Phone:		Work Phone:		Cell Phone:	
SSN: - -		Date of Birth (DOB): / /		Gender: Female ___ Male ___	
Employer:			Job Title:		
Emergency Contact:			Phone #:		
Referring Physician:			Phone #:		
Primary Care Physician:			Phone #:		
Reason for referral:					

Please indicate the main reason you chose Greater Rochester Physical Therapy? ("X" appropriate box)

Close to home	Close to work	Referred by friend/family	Referred by doctor	Phone book	Internet	Advertisement
Interested in receiving GRPT information via email? Enter your Email address:						

Billing Information

Person responsible for billing:		Relationship to patient:	
SSN: - -	DOB: / /	Phone#:	
Address (if different from above):			

Primary Insurance Information

Insurance Company:		ID #:	Subscriber Name:	
Subscriber DOB: / /		Subscriber SSN: - -		Insured's Employer:
Relationship to patient:				

Secondary Insurance Information

Insurance Company:		ID #:	Subscriber Name:	
Subscriber DOB: / /		Subscriber SSN: - -		Insured's Employer:
Relationship to patient:				

Workers' Compensation or Motor Vehicle Information Only

Date of Injury:		Insurance Phone:	
Insurance Company:		Insurance Fax #:	
Case Manager's Name:		Carrier Case or claim #:	

Greater Rochester Physical Therapy Patient Agreement

- I authorize payment directly to Greater Rochester Physical Therapy for services received, based on the accurate and current information that I provide regarding my insurance carrier. Any charges not covered by my contracting insurance carrier are my responsibility to pay in full. I am obligated, under my HMO contract, to pay any designated co-payment. There will be a \$10.00 fee if copay is not paid at the time service is rendered. If my account is not paid in full in sixty days, I agree to pay all reasonable attorney fees and collection costs that the Practice incurs in collecting such past due amounts.
 - It is my responsibility to have a current prescription written by my referring physician and I must obtain any necessary HMO (Aetna/Blue Choice/Preferred Care) referral.
 - Should I need to cancel or reschedule my appointment, I will give at least 24 hours notice. I understand that I may be charged a cancellation fee if 24 hours notice is not given. I will arrive on time for my scheduled appointments; if I am late, I understand that I may need to reschedule the appointment.
 - I consent to have Greater Rochester Physical Therapy use and disclose my Protected Health Information (PHI) for payment, treatment and health care operations and for such other purposes that are permitted under HIPAA, without my written authorization.
 - I understand that Greater Rochester Physical Therapy has privacy policies in place. I acknowledge the receipt of Greater Rochester Physical Therapy's Privacy Notice, bearing an effective date of April 13, 2003. **If you wish to designate an individual access to your Protected Health Information - please indicate here:**
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I understand and agree to the above stated terms.

Name of patient (please print)

Signature of patient

Date

**Signature of Parent/Guardian/Personal Representative
(e.g. Parent if a minor, guardian, Attorney-In-Fact)**

Date