Marquis Physical Therapy & Spine Rehab, P.C.
David E. Marquis, DPT

REGISTRATION FORM

Patient Information

Patient Name: ____ Birth Date: ____________ Age______ M F
Last First MI

SS# _______-_____-_______ Marital Status: Married Single Divorce Widow Separated

Street Address: ________________________________ City: __________________ State: _______ Zip: _______

Mailing Address: ______________________________ City: __________________ State: ______ Zip: ________

Best Phone #: (_____)______________ Alternative Phone #: (_____)______________

Employer Name: __________________________ Full Time: ____ Part-Time: ____ Phone #: (_____)__________
Referring Physician: ____ Phone #: (_____)______________
Primary Care Physician, (if different): ___________________________________ Phone #:(_____)___________
Emergency Contact: ________________________ Relationship_____________ Phone#:(_____)_____________

Spouse/Parent Information (fill in only if you are <u>not</u> the insurance policy holder)
Name: ____ Birth Date: ____________ SS# ______-___-______
Address (if different): ____________________________ City: _______________ State: _______ Zip: ________

Previous PT Treatment:
Have you had Physical Therapy Treatment in another facility this year? _________________________________
If so where? ____

Accident Information
Was this a result of an accident/injury? YES NO If YES, Date of accident: __________________________
Place of accident?: Home: ______ Work: ______ Car: _____ Other (specify): __________________________
If work related, who was your employer at the time of accident?: _______________________________________

Insurance Information
Primary type of Insurance: Group Health______ Medicare_____ W/C____ Auto____ Self-pay___ Other_____
Insurance company: ____ Phone#: (____)_______________________
Insured's Name: ____________________________
ID/Claim # ______________________________ Group#: ______________________________
Is attorney involved with this claim? YES NO
If yes, Attorney's name: ____ Phone#: ____________________

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Patient Signature **Date**

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FEES AND FINANCIAL AGREEMENTS

INITIAL► _____ **No Show Policy:**
I understand that a 24 hour notice is required for cancellation of an appointment. If I no show/cancel in less than 24 hours $40.00 will be charged to my account.

INITIAL►_____ **Waiver for Uncovered Services:**
I understand that supplies are not generally covered by insurances and that I may be requesting services that are not covered by my carrier. I assign to, and approve direct payment to Marquis Physical Therapy & Spine Rehab of insurance benefits for services provided. I am financially responsible for charges not covered by this assignment. I understand that it is my responsibility to verify with my insurance company what my Physical Therapy benefits are, along with my financial obligation for therapy treatments.

INITIAL ►_____ **Finance Charge:**
Marquis Physical Therapy & Spine Rehab will apply a finance charge to my account(s) if I am in the process of being sent to a collection agency (no payments made in over 90 days). To avoid being billed any finance charges I agree to make monthly payment until my balance is paid in full. And I am encouraged to contact the Marquis Physical Therapy & Spine Rehab billing department if I need to set up a payment plan.

INITIAL ►_____ **Cash Pay Patients:**
I understand that payment for therapy is due at the time of service and that Insurance will **not** be billed by Marquis Physical Therapy & Spine Rehab. All costs accrued are my responsibility.
Marquis Physical Therapy & Spine Rehab will **not** retro bill any insurance once cash pay status has been established.

INITIAL ►_____ **Insurance Fees:**
We call your insurance as a courtesy and benefits quoted are not a guarantee of payment. We encourage you to call and verify the physical therapy benefits your plan offers.
You have a ________deductible to meet before your plan will pay. You have met _______ of your deductible this year. You have a _______ copay/coinsurance that is due at each visit/billed to your account after you meet your deductible. You have a ________ out of pocket/coinsurance max which you have met _______of.

INITIAL ►_____ **Please initial that you have received a copy of the Notice of Patient Information Practices**

I've read & agree to all the above statements.

Patient Signature **Date**