Procare Physical Therapy, P.C.
60 West 94th Place
Crown Point, IN 46307

Registration

Date:

Name
Last First MI

Date of Birth: Age: Social Security No.:

Street Address:

City: State: Zip:

Home phone: **Cell:**

Are you single/married/divorced Spouse name:

Emergency contact name: Phone #:

Are you currently working? Yes/No Employer:

Primary Insurance Company:

Insured Name: Date of Birth:

Relationship to the insured:
ID#: Group #:
Insured Employer:
Secondary Insurance Company:
Insured Name: Date of Birth:
Relationship to the insured:
ID#: Group #:
Relationship to the insured:
Insured Employer:

Why do you need physical therapy?

Approximately when did your problem start?
Is your problem work related? Yes/No If yes,when:
Have you have surgery for this? Yes/No If yes, when:
Is this related to an auto accident? Yes/No If yes, when:

Do you have a pacemaker? Yes/No **Are you diabetic? Yes/No**
Are you pregnant? Yes/No **Do you have seizures? Yes/No**

Please list current medications (may provide list)

Other medical problems:

By signing your name, you, the patient or legal guardian of such patient attests that the above information is true to your best knowledge and you agree to the services that are about to be rendered to you by the professional staff at ProCare Physical Therapy, P.C. at 60 west 94th Place, Crown Point, IN 46307.

Patient or Guardian's Signature: **Date:**

Printed name from above:

Authorization

I hereby authorize the release of pertinent medical information to my insurance carriers, and I agree to the assignment of benefits to the physical therapist. I am aware that health insurance coverage varies and while insurance carriers may use such terms as customary, reasonable, etc. to limit their coverage, I am ultimately responsible for the payment of all charges for services rendered by ProCare Physical Therapy, P.C., plus any other fees as a result of the treatment rendered. I understand that I will be responsible for any co-payments, deductibles, co-insurance or any services that are not considered medically necessary by my insurance company but are required for the care of my condition.

I understand that it is my responsibility to notify ProCare Physical Therapy, P.C. if my insurance requires pre-certification for physical therapy services and to know and understand my insurance coverage and limitations for physical therapy services.

I understand and agree that payment will be due within thirty (30) days from the date of my statement with a patient due balance. It will be my responsibility to contact my insurance carrier to determine and handle any delays in the processing and payment of my account. I understand that if the bank returns my check for insufficient funds, there will be a $30.00 processing fee that I will be responsible for.

In the event my account with ProCare Physical Therapy, P.C. is not paid in full within 90 days from the date of service, my account will be turned over to a collection agency unless prior payment arrangements have been made. In the event that it is necessary to turn my account over to a collection agency, I will be responsible for all balances on my account with this office as well as additional costs as a result of collections, including attorney fees and interest charges.

Authorization & Release

I have read and fully understand the Office Policy Agreement as outlined above.

Patient or Guardian's Signature **Date**

Printed Name **Date**

Patient's Printed Name