DIAZ-OLSON

Physical Therapy and
Sports Rehabilitation, Inc.

PATIENT REGISTRATION FORM

PERSONAL INFORMATION		
NAME:	DATE OF BIRTH:	
GENDER: ☐ MALE ☐ FEMALE	OTHER:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	
WORK PHONE:		

REFERRING PHYSICIAN	
NAME:	PHONE NUMBER:

EMERGENCY CONTACT	
EMERGENCY CONTACT NAME:	RELATIONSHIP:
EMERGENCY CONTACT PHONE:	

INSURANCE BENEFITS / PATIENT RESPONSIBILITY - OFFICE USE ONLY*

INSURANCE:	**ID NUMBER:**
DEDUCTIBLE:	DEDUCTIBLE MET:
COINSURANCE/COPAY:	VISIT LIMIT PER YEAR:
OUT-OF-POCKET MAX:	OUT-OF-POCKET MAX MET*:
I understand the estimated charges and will pay at the time of service or when I am billed.	

*This section will be filled out by the office staff.
If you have any questions regarding your PT benefits, please contact your insurance provider.

Patient Initial: _____

APPOINTMENT REMINDERS

I would prefer to have my appointment reminder delivered by (CHOOSE ONE):

A: TEXT MESSAGE: ☐ AT&T ☐ VERIZON ☐ TMOBILE ☐ OTHER: _____

B: EMAIL AT: _____

C: PHONE CALL: ☐ HOME ☐ CELL ☐ WORK

D: NO REMINDER ☐

Patient Initial: _____

CANCELLATION POLICY

If I intend to miss my appointment, I must call and cancel at least twenty-four hours in advance to avoid a $50 cancellation or no show fee. (This cannot be billed to my insurance.)

Patient Initial: _____

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PAYMENT POLICY

I am responsible for my deductible, co-payments, and any amounts not covered by my insurance company. Payment is due at time of service. As a courtesy DO PT will bill my insurance carrier for the services rendered. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Initial: _____

INSURANCE BENEFITS

The insurance benefits quoted to me are from the date of verification of benefits and eligibility. If I continue my treatment between multiple calendar or plan years my benefits may change and it is my responsibility to monitor these changes and pay any differences. If my plan has a limit on visits or revokes payment at anytime, I am responsible for the visits not covered by my insurance.

Patient Initial: _____

CONSENT FOR TREATMENT

I consent to have Diaz - Olson Physical Therapy and Sports Rehabilitation provide the treatment and care prescribed by my physician(s). I understand that this treatment may be given in an open gym setting. I understand this consent may be revoked by me at any time.

Patient Initial: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS AND INFORMATION

I hereby authorize the release of any medical records and information, including statements of my account pertinent to this injury or illness, which are necessary to process my claims.

Patient Initial: _____

All information provided by me is true to the best of my knowledge and I will notify Diaz - Olson Physical Therapy of any changes that need to be made to my file.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____