Registration Form

Patient Name: ______________________________________ Birthday: ____________________

Phone: (____) _____-_________ E-mail: ____

Address: ______________________________ City, State, Zip: ______________________________

Text Reminders? Y N Social Security #: _____________ Marital Status: ______________

Patient's Employer: ___________________________________ Phone: (____) ____-_________

Emergency Contact: _______________ Relationship: ______ Phone: (____) ____-_________

Date of Injury: _________ Injury Due to (circle): MVA On-the-Job Surgery Chronic Other

Injury to be Treated: ____

Physician/Surgeon Name (First and Last): ____

Please Present your Insurance Cards and Driver's License for Copying.

Primary Insurance: ______________________ Secondary Insurance: ______________________

Please Complete if Your Insurance is Through Your Spouse or Parent:

Spouse/Parent's Name: __________________________________ Birthdate: _______________

Spouse/Parent's Social Security #: __________ Spouse/Parent's Employer: _______________

Spouse's Phone: (____) ____-_________

Complete the following section for Motor Vehicle Accident (MVA) or Workers Compensation claim.

We need a Claim Number: _____________ Please supply copies of Commercial Ins. Cards.

Insurance Company Name: __________________ Ins Company Phone: (____) ____-_________

Adjustor's Name and Telephone Extension: ____

Address: _______________________ City/State/Zip: ___________________________________

I hereby authorize this medical service provider to furnish my insurance companies, including Medicare, with all information requested relating to my illness or injury. I authorize payment to be made to this medical service provider by commercial or government insurance companies for treatment and supplies provided, not to exceed my indebtedness. A quote of benefits and/or authorization does not guarantee payment or verify eligibility.

I understand that I am financially responsible to this medical service provider for all expenses incurred, and that my insurance carrier may apply amounts to deductible, copays, and/or coinsurance, for which I will be billed and must pay to this medical service provider. If there is a question regarding the payment or denial of any claims, I understand that I must contact my insurance representative for clarification. I further understand that if there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.

Consent for Treatment

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent and authorize Aero Performance and Physical Therapy, its agents, associates and employees, to provide care and treatments to me per program policy and/or as prescribed by my physician. A representative of Aero Performance and Physical Therapy will explain my plan of care and answer my questions. I understand that the care plan may change and, if so, these changes will be discussed with me. I agree to notify Aero Performance and Physical Therapy, my physician or others providing care of any adverse reactions or other significant events relating to my health. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition by Aero Performance and Physical Therapy, its agents, associates, and employees. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient/guarantor. I have read, understand and agree to the terms of this agreement freely and voluntarily and intend by my signature that this be a complete and unconditional release of all liability to the greatest extent allowed by law.

Privacy Practices Consent

I have read and fully understand Aero Performance and Physical Therapy's Notice of Privacy Practices. I understand that Aero Performance and Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provided and administrative operations related to treatment or payment. I authorize the release of information left in a voice mail or text message and understand there is some level of privacy risk associated with this form of communication. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify Aero Performance and Physical Therapy in writing. I also understand that Aero Performance and Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests of restriction. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Aero Performance and Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying Aero Performance and Physical Therapy in writing at any time.

Assignment of Benefits

I hereby assign all medical benefits to which I am entitled to Aero Performance and Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. By providing us with your wireless/cell phone number, you are hereby granting us and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Aero Performance and Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Patient/Guardian Signature: ___________________________________ Date: ___________________