PATIENT REGISTRATION AND AUTHORIZATION

Name____ Date of Birth_____/_____/_______
Home phone #______________________________ other phone #_________________________
Mailing Address___________________________________City_______________Zip_________
Social Security #_________________________ Employer__________________________________
Referring physician___________________________ Primary physician________________________

Payment options (check one):

__1. I will be paying personally for my physical therapy treatments. (skip to the ***Agreement*** below.)
__ 2. Please bill my insurance company for payment. (Complete the following.)

⇒ If you have a card(s) for copying, complete only the name of your insurance(s).

PRIMARY INSURANCE____________________________ Phone__________________________
Address ___________________________________City, State, Zip________________________
Subscriber ID/Policy #_______________________ Group/Claim #________________________

SECONDARY INSURANCE _________________________ Phone________________________
Address______________________________________ City, State, Zip_____________________
Subscriber ID/Policy #_______________________ Group/Claim #________________________

Are you the "subscriber"? Yes ☐ No ☐
If not, what is your relationship to the subscriber?
Spouse ☐ Child ☐ Other ☐ (explain) ________________________________
Subscriber Name_____________________________ Subscriber's Date of Birth ____/____/____

Is your injury due to a Motor Vehicle Accident? _____ (Date of injury ___________________)

Is this is a Worker's Compensation claim? ____ If so, please complete:
Date of injury ___________ Full Name of Employer____________________________________
Person to contact___________________________________ Phone________________________
Street Address____ P.O. Box ____________
City_______________________________________ State ___________ Zip ____________
WC Insurance _____________________________ Claim Adjuster___________________________
Phone___________________________ Approved by ______________________________________
Special Instructions ____

Agreement:

I agree with the attached financial policy. I authorize release of my physical therapy chart information to Medical Management Support Services, the above insurance companies and the referring physician and also authorize payment to be made directly to Jacksonville Physical Therapy.

Patient's signature____ Date_______________

Guarantor's signature____ Date_______________