



## PATIENT REGISTRATION FORM

Thank you for choosing Alternative Therapy. Please Print. All information will be confidential

Date: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Florida Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Out-of State Address: \_\_\_\_\_ City/St: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Sex:  Male  Female

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**PREVIOUS P.T. THIS YEAR?**  Yes  No If yes, how many visits? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone: \_\_\_\_\_

### MEDICAL INSURANCE INFORMATION

Insurance (circle one): Medicare Commercial PPO Workmen's Comp. Car Ins. Non-PPO

Insurance Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_ Date of Accident: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Circle One: Workers Comp. or Auto

Secondary Insurance Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

ALL UNPAID ACCOUNT BALANCES WILL BE CONSIDERED DELINQUENT SIXTY (60) DAYS FROM THE DAY OF CHARGE. ANY DELINQUENT ACCOUNT REFERRED TO A COLLECTION AGENCY WILL BE RESPONSIBLE FOR THE COST OF THE COLLECTION INCURRED BY ALTERNATIVE P.T., INC. INCLUDING ATTORNEY'S FEE. I hereby authorize my insurance company, including private medical insurance and other health plan to pay benefits to which I am entitled for services rendered by Alternative P.T., Inc. This will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I authorize Alternative P.T., Inc. to release any information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also authorize the release of medical reports and other pertinent information to my referring physician or any other medical personnel involved with the prescribed treatment initiated on this date.

I, \_\_\_\_\_, have read a copy of Alternative Therapy's Notice of Privacy Practices. I hereby give Alternative Therapy my consent for treatment.

\_\_\_\_\_  
Signature of patient (Parent if minor)

\_\_\_\_\_  
Date