



# New Patient Registration

Advanced  
Therapy Specialists  
Physical Therapy | Occupational Therapy

Today's Date \_\_\_\_\_

## Patient Information

Full Name (First, M.I., Last)		Nickname (if applicable)
Address		
City, State, Zip Code		
Date of Birth		
Email Address		
Marital Status	Married ( ) Single ( ) Minor ( ) Widow/Widower ( )	
Cell Phone	( )	
Home Phone	( )	
Employer Name/School or College		
Work Address, City, State, Zip		
Work Phone	( )	
Gender	Male ( ) Female ( ) Other ( )	
How did you hear about Advanced Therapy Specialists?		

## Emergency Contact Information

Emergency Contact Name		
Emergency Contact Phone	( )	Cell ( ) Home ( )
Emergency Contact Relationship		

## Referring Physician Information

Referring Physician		
Physician Address, City, State, Zip		
Physician Phone	( )	Date of Referral:

## Primary Care Physician (PCP)

Physician Name		
Address, City, State, Zip		
Physician Phone	( )	Date of Last Appt:

## Injury/Condition

Is this injury/condition related to	<b>Work?</b> Yes ( ) No ( ) <b>Auto?</b> Yes ( ) No ( )	
Date of accident, injury or onset of symptom?		
If auto accident, please provide the name of the insurance adjuster/case manager		
Insurance adjuster/case manager phone number	Cell ( )	Work ( )

### Primary Insurance Company Information

Primary Insurance Company Name		Identification Number		Group Number	
Address	City		State	Zip Code	Phone
Policyholder		Policyholder's Address		Policyholder's DOB	
Policyholder's SS #		Phone Number		Relationship to Patient	
Employer of Policyholder					

### Secondary Insurance Company Information

Secondary Insurance Company Name		Identification Number		Group Number	
Address	City		State	Zip Code	Phone
Policyholder		Policyholder's Address		Policyholder's DOB	
Policyholder's SS #		Phone Number		Relationship to Patient	
Employer of Policyholder					

### Medicare Patients Only Questionnaire

**I am covered by Medicare because I am:**  
65 and older ( ) under 65 and disabled ( ) over 65 and have ESRD or on disability ( ) under 65 and have ESRD ( )

- Official retirement date:    /    /
- Are you currently being seen by a Home Health Agency? Yes ( ) No ( )
- Is your ailment due to: Motor vehicle accident ( ) Work related injury ( ) Liability ( )
- Are you receiving Black Lung Benefits: Yes ( ) No ( )

### Assignment of Benefits/Authorization to Release Medical Information/Consent to Treatment

- I hereby assign all medical benefits to which I am entitled to Advanced Therapy Specialists 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 (up to 40% of outstanding balance). 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 (up to 40% of outstanding balance). 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.
- Interest may be charged at a rate of 1.5% per month (18% annually for unpaid balances over thirty days old).
- 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 Advanced Therapy Specialists 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 Signature:	Today's Date:
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**We will contact your insurance company to inquire about benefits; however, this is not a guarantee of coverage. We recommend you contact your health insurance company directly to review benefits.**