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 ( )	
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	( )	
Injury/Condition		
Is this injury/condition related to	**Work?** Yes ( ) No ( ) **Auto?** 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	Gender

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	Gender

Policyholder's SS #	Phone Number	Relationship to Patient

Employer of Policyholder

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 1:	Patient Signature 2:	Today's Date:

If the patient is less than 18 years of age, a parent or legal guardian must sign below. Or, if signed by a person other than the insured, please complete the following.

Authorized Signature:	Phone:	Parent Date of Birth:

Address (if different than the patient)	Today's Date:

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.