Amelia Physical Therapy Registration Form for Minors

Patient Name_____
Last First Middle Initial Nickname

Street Address_____

City_____ State_____ Zip_____

Phone (H)_____ Date of Birth_____ Age____ Gender: _____

Policy Holder's Name_____ Relationship: _____Date of Birth _____

Address _____ Social Security #:_____

Employer: _____Address: _____

Email or Text Reminder? (Circle one and if text reminder, provide carrier's name)

*Email: _____Cell: _____Carrier _____

Please provide email address so we can send you a survey at the end of treatment.

Emergency Contact:

Name_____ Relationship_____

Phone(H)_____ (W)_____ (C)_____

Auto Accident_____ State Occurred _____ Date of Injury_____

Name of referring doctor and date of next follow up: _____

If coming Direct Access please complete: Chief Complaint _____

Are you under a Doctor's care? _____ Doctor's name _____

I give consent to release all records to my doctor. (If identified above)
Medicare and United Healthcare require a prescription from the doctor.

Signature_____Date_____

Responsibility for Payment:
I acknowledge that I am responsible for payment of all services and supplies if my insurance does not pay or is paid to me. If my account goes to collection status, I agree to pay all fees including registered mail fees, court courts and attorney fees of 33%.

Assignment of Benefits
I authorize payment of medical benefits to myself or the named provider for professional services rendered.

Release of Information:
I authorize the release of any medical information necessary to process this claim or to collect payment.

Signed_____Date_____

If mailing address is different than street address, please write the mailing address below:

_____

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