# COMSTOCK PHYSICAL THERAPY PATIENT REGISTRATION

## PATIENT INFORMATION

Patient Name: ____________________________ Birthdate: _________ Age: _______ Gender: ____________
Address: ____________________________________________________________________________________
City/State/Zip: ______________________________________________________________________________
Employer: ___________________________________ Position: _____________________________________
Referred to this office by: ____________________________________________________________________

## VISIT REASON

Problem for which you are seeking treatment: _____________________________________________________
If caused by an accident, how did it happen: _____________________________________________________
__________________________________________________________________________________________
Where did it happen: ____________________________________ Date of injury: _______________________

Is it: Work-related ☐ Auto accident ☐ School sport ☐ Other ☐

Claim #: ________________________ Attorney name: _______________________________________________

*If this is a workers compensation claim or an automobile claim, please provide your private medical insurance name and ID in the section below.*

## INSURANCE INFORMATION

Insurance Name: ________________________________ Insurance Phone #: ___________________________
Subscriber Name: ______________________________________Subscriber Birth Date: __________________
Subscriber ID #: _______________________________________ Subscriber ID Group #: _________________

**Do you have a secondary insurance plan that covers you? Yes ☐ No ☐** **<u>IF YES:</u>**

Insurance Name: ________________________________ Insurance Phone #: ___________________________
Subscriber Name: ______________________________________Subscriber Birth Date: __________________
Subscriber ID #: ___________________________________Subscriber ID Group #: _____________________

## INCASE OF EMERGENCY

Name: ____________________________________ Relationship: ____________________________________

Home Phone #: ___________________________Work or Message Phone #: __________________________

*I hereby authorize the physical therapists and professional staffs to consult, examine, perform and treat the patient's problem. I understand that I am financially responsible for all charges incurred by me or my dependent.*

__________________________________________________________________________________________
**PATIENT SIGNATURE** *(Parent or guardian if patient is a minor)* **DATE**

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE POLICIES

*Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgement of having had an opportunity to receive and review a copy of our Notice of Privacy Policies*.

## DISCLOSURE TO FAMILY AND FRIENDS AND CONTACT INFORMATION

*Under normal circumstances we may share some of your private health information (PHI) with some of your family members.*

☐ **I *do* want** this office to disclose my private health information to only the following individuals that are my family members or friends. (Please check all that apply):

**☐My spouse ☐My parents ☐Any of my children ☐Any of my siblings ☐Attorney**
**☐Other**________________________________________________________

☐ **I do *NOT*** want my private health information disclosed to ***any*** individual asking about me, ***regardless of whether or not they may be a family member or friend.***

**Please provide your preferred phone numbers for scheduling appointments / reminder calls & texts**

☐ Home: __________________________________ Voicemail okay? Yes ☐ No ☐
☐ Work: ___________________________________ Voicemail okay? Yes ☐ No ☐
☐ Cell: ____________________________________ Voicemail okay? Yes ☐ No ☐
☐ Email Address: ____________________________________

May we send exercises, minor communications, flyers etc. to you via HIPAA-secured email? Yes ☐ No ☐

May we send you minor communications via text message? Yes ☐ No ☐

**Please choose the best way for us to remind you about your upcoming appointments:**

☐ Text ☐ Email

☐ I do ***NOT*** want *Comstock Physical Therapy* to send me appointment reminders.

*I acknowledge the opportunity to review and receive the Notice of Privacy Policies for Comstock Physical Therapy.*

________________________________________________________________

**PATIENT SIGNATURE (***Parent or guardian if patient is a minor)* **DATE**

## GUARDIAN INFORMATION

Parent/Guardian Name: ___________________________________ Birth Date:__________ Age:_____
Address: ______________________________________________ Home Phone#:____________________
City/State/Zip: ________________________________________ Work Phone#:______________________
Employer: _______________________________________Relationship to Patient: ______________________

Is Patient a Student? Yes ☐ No ☐ Part Time ☐ Full Time ☐