# 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 ☐ IF YES:**

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

*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.***

## CONTACT INFORMATION & METHODS OF COMMUNICATION

☐ Home: _____Voicemail Okay? Yes ☐ No ☐

☐ Work: _____Voicemail Okay? Yes ☐ No ☐

☐ Cell: _____Voicemail Okay? Yes ☐ No ☐

☐ Email Address: _____

May we send exercises & minor communications to you via unsecured email? Yes ☐ No ☐

May we use secured email to send you Personal Health Information? Yes ☐ No ☐

May we use unsecure text messaging to arrange scheduling if necessary? Yes ☐ No ☐

May we send you text and email reminders?

☐ I ***DO*** want *Comstock Physical Therapy* to send me appointment reminders.

☐ 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.*

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**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 ☐