Patient Express Registration

ATHLETICARE
Physical Therapy & Sports Performance

Please Fill-Out Entire Form Completely and Legibly

1. Personal Info

Today's Date:

_____ _____ ☐ Male ☐ Female
Last Name First Name

_____ _____ _____ _____
Street Address City State ZIP

(_____)_____ (_____)_____ _____
Home Phone Cell Phone Email Address

_____/_____/_____ _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Other
Date of birth Age

Work Status: ☐ Currently Employed ☐ Retired ☐ Disabled (___Total ___Temporary) ☐ Student (___P/T ___F/T)

_____ _____
Occupation Employer Name

_____ (_____)_____ _____
Emergency Contact Person Phone # Relationship to Patient

My condition is related to: ☐ Work ☐ Auto Accident (State) ☐ Other_____

2. Referral Info

_____
How did you hear about us?

_____
Referring Physician Name

Do you have a follow up appt. with this physician?

☐ Yes ☐ No If yes, when?_____

Important: Have you had any therapy (physical/ occupational/speech/chiropractic) this calendar year?

☐ Yes ☐ No If yes, please provide details, as this may affect your insurance benefits:_____

_____

3. Payment Info

I have **INSURANCE** and would like to. . .

☐ Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form".

☐ Get a discount by paying the entire bill at the time of service. I'll get reimbursed on my own. (Ask for details).

I am **NOT USING INSURANCE** and would like…

☐ A discounted rate by paying at the time of service.

I have an **ATTORNEY** and would like to. . .

☐ Pay the entire bill at the time of service. I'll get reimbursed after my case settles.

☐ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

4. Consent To Treat

I hereby authorize AthletiCare, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize AthletiCare to release to the appropriate agencies, any information acquired in the course of my or the above-referenced patient's examination and treatment necessary to secure payment for services provided.

I understand that AthletiCare reserves the right to charge a $25.00 fee for any missed appointments or cancellations without at least 24 hours notice.

_____ _____ _____
Signature of Patient or Parent/Guardian (Responsible Party) Name of Responsible Party Relationship to Patient

Dated this _____ day of _____, 20_____.