TOSPT
TALLAHASSEE ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Patient Registration Form

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____

State: _____ Zip code: _____ SS number: _____ Date of birth: _____

Please check all the ways we can contact you

☐ Home phone: _____ ☐ Cell phone: _____ ☐ SMS/Text on cell

☐ E-mail address: _____ ☐ Work phone: _____

Please keep in mind that communications via email over the internet is not a secure form of communication.

Employer and Employer phone number: _____

Who is your General Physician: _____

2nd contact person name/address: _____

Phone Number: _____ Relation: _____

Please Fill Out the Following Information If Different from Above

Primary

Policy holder information: _____
(name, address, Insurance plan name)

Policy holder DOB: _____ ID/SS#: _____ Group number: _____

Secondary

Policy holder information: _____
(name, address, Insurance plan name)

Policy holder DOB: _____ ID/SS#: _____ Group number: _____

Is this work related? Yes No **If yes**, Date of Injury: _____

Employer address:_____

Is this Motor Vehicle Accident related? Yes No **If yes**, State _____ and Date of accident: _____

How did you hear about us? ☐ Physician Referral, who referred _____ ☐ Family or Friend

☐ Industry ☐ Advertisement (please list) _____ ☐ Other (please list) _____

I hereby authorize and consent to treatments/services for myself, or on the behalf of the above-named patient, performed by the staff at Tallahassee Orthopedic & Sports Physical Therapy and/or as directed by my referring physician.
I assign medical benefits payable for these services directly to Tallahassee Orthopedic & Sports Physical Therapy. I authorize the release of any medical or other information necessary to process claims for these services.
I understand that I am responsible for payment of any applicable co-payments, co-insurance, deductibles or non-covered services at the time of service. In Medicare assigned cases, Tallahassee Orthopedic & Sports Physical Therapy participates in the Medicare program and accepts Medicare's allowed amount for covered services, less any co-pay, co-insurance, deductible or non-covered services.
In signing this form I acknowledge that I am responsible for the bill not paid by the insurance carrier.
I understand that my health information will be used for treatment, payment and healthcare operations in accordance with the Notice of Privacy Practices.
By providing your contact information, you agree to receive information, such as appointment reminders, patient surveys and other information relating to your therapy services via the communication channels you provided above.

_____ _____
Patient/Legal Guardian Signature Date

Relationship to Patient: _____

_____ I acknowledge receipt of the Notice of Privacy Practices which provides information on how my Protected Health Information may be used or disclosed, if I have any questions I can contact the Compliance Department.
Initial