

STI Physical Therapy & Rehabilitation

Please Complete Each Item on This Registration Form **Account No:** _____

Patient Name: _____ (_____) _____
Last Name First Name Middle Home Phone No

If the Patient is a Minor, a parent or Guardian must complete separate form.

Address: _____ Apt No.: _____ City: _____ State: _____ Zip: _____

Patient SS #: _____ Date of Birth: _____ Male: _____ Female: _____ Height: _____ Weight: _____

Prescribing Physician: _____ Telephone No: _____ Fax No: _____

Injury Information: Must Be Completed! THEN COMPLETE THE CORRECT INSURANCE INFORMATION SECTION!

Is the Injury Related To? AUTO ACCIDENT? _____ WORK RELATED? _____ OTHER? _____

Employer: _____ Phone Number: _____ Supervisor: _____

Injured Part of Body: _____

Occupation (Description of Duties): _____

Insurance (Guarantor) Information: NON Worker's Related Injury. This section must be as complete as possible.

Responsible Party SS# _____ Relationship to Insured: Self ___ Spouse ___ Child ___ Other ___

Primary Insurance: _____ Insured: _____

Insurance Phone No: _____ ID Number: _____

Group Number: _____ Insured's DOB: _____ Employer: _____

Secondary Insurance: _____ Insured: _____

Insurance Phone No: _____ ID Number: _____

Group Number: _____ Insured's DOB: _____ Employer: _____

Worker's Compensation Information:

Employer @ Time of Injury: _____ Date of Injury: _____

Industrial Insurance Carrier: _____ Claim No: _____

Case Manager/Nurse/Claim Adjuster: _____ Telephone No: _____

Personal Injury Information: If You Have An Attorney, Complete The Attorney Information.

Attorney Name: _____ Telephone No: _____

Address: _____ Date of Injury: _____

Is there auto/med pay available? _____ Insurance Name: _____ Telephone No: _____

Emergency Information:

Relative Not Living With You : _____ Telephone No: _____

**ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY
THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING**

1. I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the costs of interest, collection and legal action (if required).
2. I authorize my insurance carrier to release information regarding my coverage to STI Physical Therapy/Strength Training Inc. I also authorize agents of any hospital, treatment center or previous physicians to furnish STI Physical Therapy/Strength Training Inc copies of any records of my medical history, services or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any physician or insurance carrier as needed.
3. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and medical services including major medical benefits are hereby assigned to STI Physical Therapy/Strength Training Inc. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to STI Physical Therapy/Strength Training Inc.

Patient Signature

Date/Time AM or PM (circle one)

Responsible Party Signature Relationship

Date/Time AM or PM (circle one)