PRO•MOTION PHYSICAL THERAPY

Join the *Movement*

Registration

Welcome to Pro•Motion Physical Therapy

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. We do require 24 hours notice of a cancellation, or you may be charged a $25.00 fee non reimbursable from your insurance company as per Medicare guidelines.

Name _____ Date: _____
First Middle Last

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Birth Date _____/_____/_____ Sex (circle one) M F Referring Doctor: _____

Occupation _____ SSN: _____ Spouse SSN _____

Employer _____ Work Phone _____

Employer's Address _____

City _____ State _____ Zip _____

Insurance Information

Please give a copy of your insurance card(s) to the receptionist

Primary Insurance

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insured's Name _____ Insured's Birth Date _____/_____/_____

Group Number _____ Policy ID Number _____

SSN _____ Insured's Relationship to Patient _____ Insured's Sex (circle one) M F

continued on next page

PRO·MOTION PHYSICAL THERAPY

Registration *cont'd*

Insurance Information *cont'd*

Secondary Insurance

Name of Insurance Company _____

Address _____

City _____ State _____ Zip _____

Insured's Name _____ Insured's Birth Date _____/_____/_____
First Middle Last

Group Number _____ Policy ID Number _____

SSN _____ Insured's Relationship to Patient _____ Insured's Sex (circle one) M F

In order to comply with the HIPPA Laws we need the following information:

I wish to be contacted in the following manner: *(check all that apply)*

Home:

___ Ok to leave message with detailed information

___ Leave message with call back number only

___ Call cell phone

Written Communication:

___ OK to mail to my home address

___ OK to mail to my work address

___ OK to fax to this number

Work:

___ Ok to leave message

___ Leave message with call back number

If I am unavailable, you may leave a message with the following people:

_____

_____

In Case of Emergency Notify _____ **Relationship** _____

Home Phone _____ Work Phone _____

Are you or your spouse currently employed?	Yes	No
Are you covered under any employer group health plan or large group health plan?	Yes	No
*Is your illness or injury due to any type of motor vehicle or personal injury accident?	Yes	No
*Are you covered by Worker's Compensation?	Yes	No

If you answered yes, please see receptionist for separate forms.

X _____
Signature

815.521.4400

901 S. Ridge Road
Minooka, IL 60447
815-521-4400
Fax: 815-521-9709
MovingPainFree.com

PRO·MOTION PHYSICAL THERAPY

Addendum to **Registration** *cont'd*

HIPAA CONSENTS: In compliance with HIPAA regulations, I give consent for the following individuals to receive verbal/written information regarding the billing of my account:

_____ _____

Name/Relationship Name/Relationship

I also authorize the release of information left in a voicemail or answering machine and understand there is some level of privacy risk associated with these forms of communication.

_____

Phone Number

I understand that authorized personnel from Pro Motion Physical Therapy may communicate with me regarding scheduling, educational information, including newsletters or services available at Pro Motion Physical Therapy. I agree to receive such communications via email at the following email address:

_____

Email Address

_____

Signature