

EXPRESS PATIENT REGISTRATION

PHYSICAL THERAPY of LAKE CHARLES

Today's Date \_\_\_\_/\_\_\_\_/20\_\_\_\_

1. PATIENT INFO (please PRINT)

Your Full Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_ Male \_\_\_ Female \_\_\_

City \_\_\_\_\_, State \_\_\_\_\_ Zip \_\_\_\_\_

Your Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

eMail Address \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Problem area \_\_\_\_\_ Related to \_\_\_ Work \_\_\_ Sports \_\_\_ Auto \_\_\_ Other

Occupation/Employer \_\_\_\_\_

~2. PAYMENT INFO (check one box)

I am paying out-of-pocket (cash) for services. Please give me a 25% discount.

Non-Cash Payment

I have insurance and would like you to deal directly with them. I will assign benefits over to you. I understand that I am responsible for any deductible, co-payment or co-insurance associated with my insurance plan.

I was injured on the job and covered by Workers' Compensation.

~I consent to evaluation and treatment and have the right to refuse any therapy after discussion of plan of care is explained to me. I authorize the release of information, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring physician and/or third party payor.

Patient Signature Required \_\_\_\_\_ Date \_\_\_\_\_