REGISTRATION
(Please Print)

SITKA PHYSICAL THERAPY

700 Katlian St., Suite E
Sitka, AK 99835
Telephone: (907) 747-4559

SSN_____ Date_____

Patient_____ DOB_____
Last First Initial

Sex: Female □ Male □ Marital Status: S □ M □ SEP □ D □ W □

Mailing Address_____ Home Phone#_____
Street Address_____ Cell Phone #_____
City/State/Zip Code_____ Work Phone #_____
Employer Name _____ Occupation_____
Employer Address_____ City/State/Zip Code _____
Email address_____

How do you wish to be notified of your appointments (please circle)??: Cell / Home Phone / Email / Text

Reason for Visit: _____

PERSON RESPONSIBLE FOR PATIENT'S FINANCIAL OBLIGATIONS, IF SELF, INDICATE SELF □

Name_____ DOB_____ SSN_____
Relationship_____ Home Phone #_____ Work Phone#_____ Cell Phone#_____
Mailing Address (If different from Patient's address)_____
Street Address (If different from Patient's address)_____
City/State/Zip Code_____
Employer_____ Occupation_____

IN CASE OF EMERGENCY

Name_____ Relationship_____
Home Phone#_____ Work Phone#_____ Cell Phone#_____
Street Address_____ City/State/Zip Code_____

PATIENT INSURANCE INFORMATION

Do you have health insurance? Yes □ No □ Is this a work related injury? Yes □ No □
What is the name of your insurance company? _____ Group # _____
Who is the subscriber to the above insurance plan? Self □ Other □ If other, please provide subscriber information below:
Name:_____ DOB_____ Phone_____ ID # _____

Name of secondary insurance carrier (if any)_____Group # _____
Subscriber _____ DOB_____ Phone_____ ID# _____

ASSIGNMENT OF BENEFITS

I hereby do authorize and direct my insurance company to make payment to SITKA PHYSICAL THERAPY, benefits allowable and otherwise payable to me and/or my dependents. I understand that I am responsible for charges not paid under this assignment. I hereby authorize the therapist to release all information necessary to secure payment of benefits. I authorize the use of this signature in all my insurance submissions.

PATIENT'S SIGNATURE_____ DATE_____

MEDICARE AUTHORIZATION (only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to SITKA PHYSICAL THERAPY for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the therapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT'S SIGNATURE_____ DATE_____

PRIVACY DISCLOSURE

I have received the *Notice of Privacy Practices* sheet and I have been provided an opportunity to review it.

PATIENT'S SIGNATURE_____ DATE_____