**NEW PATIENT REGISTRATION FORM**

Name:_______________________________________________________________DOB:_______________________

Social Security #___________________________________________________________________________________

Phone #: _______________________________________________Cell Phone #:________________________________

Address:____________________________________________________________________________________

City:_______________________________________________________State:_____________Zip:___________________

Email:______________________________________________________________________________________

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Primary Insurance:__________________________________________________________________________

Subscriber Name:______________________________________DOB_______________________________________

Secondary Insurance:___________________________________Phone #___________________________________

Subscriber Name:______________________________________DOB Subscriber____________________________

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Workers Comp/ Auto Insurance:______________________________________________________________

Subscriber Name:_____________________________________________________________________________

Claim #:______________________________________________________________________________________

Adjustor/Case Manager:_________________________________________ Phone #__________________________

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**Attendance Policy**

- Please be aware that we reserve specific time slots for each patient. Same day cancellations, no shows and late arrivals, decrease the ability to accommodate the scheduling needs of other patients.
- All cancellations and no-shows will be documented in our medical records, and reported to your physician and insurance provider.
- Workers Comp. patients: Workers comp. adjustors monitor each visit, and may discontinue your benefits/ close your case secondary to missed visits.
- Cancellations with less than 24 hours' notice will result in a $40.00 charge to the patient. If you accumulate 3 cancellations or no shows your therapist may discharge you from therapy and report this to your physician.
- Marina Physical Therapy Staff and patients appreciate your cooperation and adherence with this policy.

**Consent to Treatment, Assignment of Benefits, Authorization to Release Medical Information.**

- I hereby authorize all medical benefits for services rendered on my behalf, to be paid directly to Marina Physical Therapy. I understand that I am financially responsible for all charges not paid by my insurance. In the event of a default of payment, I agree to pay all costs of collections and attorney's fees. I hereby authorize Marina Physical Therapy to release all information necessary to secure payment of benefits. A copy of this assignment shall be considered as a valid as the original. I do consent to treatment as dictated by prudent medical practice by my illness, injury, or condition.

**Acknowledgement of Receipt of Notice of Privacy Practices for Marina Physical Therapy.**

- I've been provided with a facility copy of my privacy practice notice and if I so choose I will be provided with a copy for my own records.

Signature:____________________________________________Date:_______________