PATIENT REGISTRATION & BILLING INFORMATION **FOR MINORS**

Albany Physical Therapy ~ 948 San Pablo Ave. ~ Albany, CA 94706 ~ (510) 526-2353

NAME____DATE______________
( ) Single ( ) Married

ADDRESS____________________________________HOME PHONE__________________
WORK PHONE__________________
CITY____________________STATE_____ZIP_________CELL PHONE___________________

SOCIAL SECURITY #____________________BIRTHDATE__________AGE_______SEX_____

PARENT / GUARDIAN NAME_______________________________DOB_____________

EMPLOYED BY______________________________WK PH_______________________

OCCUPATION_____________________________ CELL PHONE_____________________

Person to call in case of emergency____________________Relation_____________Phone_____________

DOCTOR WHO REFERRED YOU__________________DATE **CURRENT** SYMPTOMS BEGAN___________

Is your condition related to an accident (auto, work, or other): _______ If yes, date of injury______________

METHOD OF PAYMENT

1) **PRIMARY INSURANCE** ________________________________ID#____________________

Insured Person's Name___________________________ DOB: __________Group #_________________

Employer________________________ Your relation to insured person: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE______________________________ ID#____________________

Insured Person's Name___________________________DOB:__________Group #_________________

Employer________________________ Your relation to insured person: SELF SPOUSE CHILD OTHER

2) **WORKER'S COMP. INS**______________________________CLAIM#____________________

Address________________________City____________________State____________Zip__________

Adjuster's Name__________________________Phone #_______________Date of Injury____________

Employer Name (at time of injury) _________________________________Are you currently working_______

Date of injury ____________________If not currently working, date you are to return___________________

3) **AUTO ACCIDENT** (or other accident insurance info)

INSURANCE CO. NAME_________________________________PHONE #________________________

ADDRESS________________________City___________________State____________Zip____________

ADJUSTER'S NAME____________________________________PHONE #__________________________

DATE OF INJURY___________________________CLAIM #___________________________________

Is this your insurance plan: ________ If not, is it the ins. of the car you were in?__________ or other car's ins_____

Do you have Med Pay on your policy? __________ If yes, how much $____________ Have you used any? $_______

Attorney's Name (if represented)___________________________Phone #__________________________

Assignment of insurance benefits & authorization to release medical information:

I hereby instruct my insurance company, or attorney, to pay to Albany Physical Therapy any benefits allowable for their professional services rendered to my child by their office. I shall be personally liable for any unpaid balance. Furthermore, I authorize Albany Physical Therapy to provide to my insurance company (or other entities I have signed a release with) any and all information they may require concerning my child's case.

Cancellation Policy:

- If you need to cancel an appointment we require at least a 24 hour notice
- If you do not give at least a 24 hour notice to cancel, or if you do not show up for your appointment ("no show"), you will be required to pay a **$75 fee** for the time we had reserved in your name. Your insurance will not pay this fee.
- After 2 late cancellations or 2 no shows, we will cancel all future appointments and if you want to continue therapy, you will be required to call in each day to see if your physical therapist has an appointment available. We will not schedule future appointments in advance.

Late Arrival Policy:

In consideration of other patients, your appointment time cannot be extended if you do not arrive on time. The therapist will determine if there is sufficient time to render quality care in the time remaining for your scheduled appointment.

Consent to treatment of minor child:

I hereby authorize any Physical Therapist at Albany PT to administer treatment as deemed medically necessary to my ______________________.

Son, Daughter, etc.

Child's Name____________________________________

Parent / Guardian's Signature__________________________________

Witnessed by: ___________________________________

Staff member at Albany PT

Please show your insurance card to the receptionist.
Please remember to notify our office immediately upon any changes to your address, phone #, or insurance coverage.

This office is a sole proprietorship, independently owned and operated.