

PATIENT REGISTRATION & BILLING INFORMATION

Albany Physical Therapy

948 San Pablo Ave Albany, CA 94706 (510) 526-2353

NAME _____ DATE _____

() Single () Married () Partner () Widowed () Divorced () Other

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Please put a check mark in the for the phone number you would like us to call to remind you of your appointments.

PHONE: HOME _____ WORK _____ CELL _____

SOCIAL SECURITY # _____ BIRTHDATE _____ AGE _____ SEX _____

EMPLOYED BY _____ OCCUPATION _____

SPOUSE'S NAME _____ DOB _____ WK PH _____

SPOUSE'S EMPLOYER _____ OCCUPATION _____

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# _____

Primary Subscriber's Name _____ DOB: _____ Group # _____

Employer _____ Your relation to subscriber: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE _____ ID# _____

Primary Subscriber's Name _____ DOB: _____ Group # _____

Employer _____ Your relation to subscriber: 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 me 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 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.

Patient's Signature _____ Date _____

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.