



**CITY SPORT  
PHYSICAL THERAPY**

*Experience you can trust.  
Personalized care you deserve.*

**J. Scott Plank,  
MS, PT, ATC**

**Patient Registration Form**  
*(Please Print)*

**Patient Information**

Date of Injury or Onset \_\_\_\_\_

Last Name	First Name	M.I.	Preferred Name
Address	City	State	Zip
Home Phone ( )	Cell/Other ( )	Work Phone ( )	Soc. Security #
Drivers' License	Date of Birth / /	Age	Sex M F
Employer	Occupation	Marital Status	Spouse's Name
Employer	Address	City, Zip	
Email:			

**Emergency Contact**

Last Name	First Name	M.I.	Preferred Name
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Relationship to Patient	
Employer	Address	City, State, Zip	

**ALL CASH PATIENTS AND PATIENTS WITH CO-PAY AMOUNTS MUST PAY AT TIME SERVICE IS RENDERED**

**Responsible party (if other than Patient)**

Last Name	First Name	M.I.	
Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Soc. Security #	
Employer	Address	City, State, Zip	

**Signature/Authorization of responsible party accepting liability:** \_\_\_\_\_

**Verified by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Is this visit a result of work injury? Y / N	Date Injured	M.I.
Is this a result of a car accident? Y / N	Date of Accident	Lien? Attorney Name
How did you hear about us?	Who can we thank for referring you to us?	

**Continued on reverse**

Our policy is that payment is made at the time service is rendered, *unless* other financial arrangements are made in advance.

I understand that upon Verification and approval of my insurance coverage, *City Sport Physical Therapy* will bill my insurance company for physical therapy services rendered. I understand that *City Sport Physical Therapy* is NOT required to bill my insurance company, but will as a courtesy to me. I understand that I, or the named responsible party is *solely* responsible for any deductible, co-payments, co-insurance or service not covered under my insurance policy. It is further understood that all co-payments or cash amounts are payable at time of service

I agree to check my insurance benefits booklet, and verify my benefits with my insurance company, even though *City Sport Physical Therapy* will contact them for benefits on my behalf, they will not be held responsible for any coverage errors my insurance company may have misquoted.

I authorize assignment of my benefits directly to *City Sport Physical Therapy*. I understand a reasonable time period will be allowed for insurance to process and remit on claims submitted by *City Sport Physical Therapy*. At the time 90 day has lapsed and insurance has not responded or paid for any claims submitted for services rendered by *City Sport Physical Therapy*, I understand that 50% of the account balance would be due, and a monthly payment arrangement would be established at that time. Understand a monthly late fee of 1.5% could be assessed, and this would be my responsibility. Furthermore, I understand there will be a \$5.00 rebilling fee for all accounts over 90 days.

Please select your method of payment and sign below that you have read and understood the above information.

\_\_\_ 1. Insurance Account – Any co-payment amount, if required, is due at the time of service. Any deductible amount not satisfied will be applied to amount not met, and is your responsibility. Percentage amount of co-insurance as determined under your policy, is the patient’s responsibility and will be billed. Any services provided and not covered under your plan’s policy is payable by the patient.

\_\_\_ 2. PPO Account – If I have a set co-payment amount, I will remit my co-payment at the time service are rendered. If my co-payment is based on percentage, I understand I will be billed as my insurance company processes my claims.

\_\_\_ 3. Cash Account – I prefer to pay for my services on a cash basis. I understand a discount is given for cash accounts and that payment is due at time services are rendered, unless payment arrangements have been made in advance.

\_\_\_ a. I do not have insurance.

\_\_\_ b. Please submit my claims to me directly so I can bill my insurance.

\_\_\_ 4. Medicare Account – I have Medicare PART B, medical benefits coverage. I understand that if I have Medicare PART A, HOSPITAL COVERAGE ONLY, Medicare will not pay for my physical therapy services, and I will be responsible for payment of services on a cash basis. I further understand that I am responsible for any deductible or co-insurance applicable under my policy.

\_\_\_ 5. Workers’ Compensation – I am covered by Workers’ Compensation. I understand that upon authorization from the insurance company, I will not be liable for any financial obligations.

\_\_\_ 6. Automobile Insurance – I am covered by my auto insurance policy. I understand verification of 100% coverage will be required with insurance benefits to be sent directly to *City Sport Physical Therapy*. I understand that NO LIENS or SETTLEMENTS are accepted by *City Sport Physical Therapy*, and any portion not paid by the insurance company is my responsibility.

ASSIGNMENT OF BENEFITS

I authorize the release of Medical Benefits directly to *City Sport Physical Therapy*. A photocopy of this authorization shall be considered as valid as the original.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if a minor): \_\_\_\_\_ Date: \_\_\_\_\_