2516 Highway 35, Manasquan, NJ 08736
732.223.6309 • ActivePhysicalTherapyNJ.com

PATIENT REGISTRATION FORM

Name: *(Last)* ______________________ *(First)* ______________________ *(MI)* ______

Home Address: ____

City: ______________________________ State: __________ Zip: ________

Home Phone: ______________________ Cell Phone: ______________________

Email *(electronic medical record requirement)*: ______________________

SSN: ______________________ DOB: ______________________

Company Name: ______________________ Position: ______________________

Address: ____

City: ______________________________ State: __________ Zip: ________

Work Phone: ______________________ Fax: ______________________

Primary Insurance: ______________________ ID#: ______________________

Secondary Insurance: ______________________ ID#: ______________________

Insured Name: *(Last)* ______________________ *(First)* ______________________ *(MI)* ______

SSN: ______________________ DOB: ______________________

Are you aware of your deductible, co-insurance and/or co-pay responsibility? ☐ **Yes** ☐ **No**

Diagnosis/Description of Ailment: ____

Physical Therapy is Treatment for: ☐ **Work Comp** ☐ **Auto** ☐ **Other**

Date of Injury or Onset: ______________________ ☐ **Surgery** ☐ **Insidious** ☐ **Chronic**

Physician Name: ____

Physician Phone: ______________________ Fax: ______________________

Emergency Contact Name: ______________________ Phone: ______________________

How did you hear about us? ☐ **Physician Referral** ☐ **Friend Referral** ☐ **Newspaper Ad**
☐ **Internet Search** ☐ **Facebook** ☐ **Other** ______________________

I hereby authorize Active Physical Therapy (Provider) to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Provider. I authorize Provider to release medical or other information necessary to process this claim. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand that I am responsible for knowing and meeting the requirements of my insurance plan.

PRIVACY POLICY ACKNOWLEDGMENT: I have reviewed the sign explaining the Notice of Privacy Practices.

CANCELLATION POLICY: I acknowledge that I may be billed $40.00 for cancellations made within 24 hours of scheduled appointments and no-show appointments.

Signature: ____ **Date:** ______________

Parent/Guardian if patient is a minor