Lake Superior Physical Therapy

Patient Registration Form

Patient Information			
❑ Mr. ❑ Mrs. ❑ Dr. ❑ Miss ❑ Ms.	First Name:	Middle:	Last Name:
Gender : ❑M ❑ F	Birth Date:	Student Status: ❑ N/A ❑ FT ❑ PT	Marital Status: ❑ Single ❑ Married
Home address:	City:	State:	Zip Code:
Mailing address (If different from above):	City:	State:	Zip Code:
Employer address:	City:	State:	Zip Code:
Patient's Occupation:	Employer:	Employer Phone:	
Primary Phone:	Home Phone:	Mobile Phone:	
Email Address:		Social Security:	

Emergency Contact Information	
Emergency Contact First and Last Name:	Phone:
Relationship to Patient: ❑ Spouse ❑ Mother ❑ Father ❑ Sister ❑ Brother ❑ Guardian ❑ Other:	

Injury Information	
Is Your Reason for Coming to Physical Therapy Injury Related? ❑ No (Go to Physician Information) ❑ Yes	
Is the injury related to: ❑ Employment ❑ Auto Accident ❑Other Liability	What Was the Date of Injury (DOI)?

Physician Information			
Primary Care Physician:		Referring Physician:	
Phone:	Next Visit:	Phone:	Next Visit:

Identification Information		
❑ **IF THIS BOX IS CHECKED, A Copy of the Patient's Identification Has Been Taken, DO NOT COMPLETE THIS SECTION**		
ID Type:	ID Number:	
Effective Date:	Source:	Expiration Date:

Insurance Information			
❑ **IF BOX IS CHECKED, A Copy of the Insurance Card(s)/Information Has Been Taken, DO NOT COMPLETE THIS SECTION**			
Insurance Company:	Policy/ID #:	Group #:	
Address:	City:	State:	Zip Code:
Phone:			

Guarantor or Responsible Party Information			
Relationship to Patient: ❑ Self (Do Not Complete This Section) ❑ Spouse ❑ Child ❑ Mother ❑ Father ❑ Other:			
First Name:	Middle:	Last Name:	
Address:	City:	State:	Zip Code
Phone:	Gender : ❑M ❑ F	Birth Date:	Social Security:

Primary Insurance Holder (Subscriber) Information			
Relationship to Patient: ❑ Self (Do Not Complete This Section) ❑ Spouse ❑ Child ❑ Mother ❑ Father ❑ Other:			
First Name:	Middle:	Last Name:	
Address:	City:	State:	Zip Code
Phone:	Gender : ❑M ❑ F	Birth Date:	Social Security:

Lake Superior Physical Therapy

Consent For Physical Therapy Treatment And Authorization To Release Information

I present myself for health care services at Lake Superior Physical Therapy Inc. to be provided by authorized employees of the clinic and medical staff as may, in their professional judgment, be deemed necessary or beneficial. I realize that among those who attend patients are medical and other health care personnel in training who, unless requested otherwise, may be present during patient care as part of their education.

I authorize Lake Superior Physical Therapy Inc. to disclose information from my medical records (including transfer of records) and/or my business office records to whom, Lake Superior Physical Therapy Inc. believes is responsible for the payment of my bill or is involved in my care and treatment. This authorization includes the responsible party named on the reverse side, and immediate family on behalf of myself and/or dependents. I hereby authorize payment of Medical benefits to Lake Superior Physical Therapy Inc. for services rendered to myself and/or dependents. I understand that I am financially responsible for all charges whether or not covered by my insurance.

Signature of Patient or Authorized Representative _____ Date _____

Lake Superior Physical Therapy Inc. Notice Of Privacy Practices

I acknowledge being offered the Lake Superior Physical Therapy Inc. Notice of Privacy Practices. _____

Initials

Financial Agreement

I agree to pay Lake Superior Physical Therapy Inc. for all services provided me by Lake Superior Physical Therapy Inc. This includes services which, for any reason, are not paid by insurance, government programs, or other third party sources. I understand that any self-pay portion of my clinic bill is due upon verbal or written notification. Any such self-pay balance remaining unpaid after 30 days will incur a **service charge of 1%** per month on the principal unpaid balance. I understand and agree that if I do not call and cancel my appointment prior to my scheduled visit and I simply do not show up, I will be charged a **$25.00 no show fee** that cannot be billed to my insurance and I accept full responsibility of payment. I further agree to pay reasonable attorney's fees and all costs (including court fees) of collection in the event my account is turned over to an attorney or collection agency.

I authorize payments be made directly to Lake Superior Physical Therapy Inc. of insurance, Medicare/Medicaid benefits or other funding sources I am entitled to as payment for services provided me. I understand that I am financially responsible for all charges, whether or not paid by insurance and for all services rendered on my behalf or my dependents. I authorize Lake Superior Physical Therapy Inc. to release the information required to secure the payment of benefits. I also authorize the use of this signature on all insurance claims, government programs, or other third party source submissions for payment.

Signature of Patient or Authorized Representative _____ Date _____

Medicare/Medicaid Patients

I request payment of authorized benefits on my behalf for any services furnished me by Lake Superior Physical Therapy Inc., and assign such benefits to Lake Superior Physical Therapy Inc. I authorize Lake Superior Physical Therapy Inc. to release to Medicare/Medicaid and its agents any information needed to determine these benefits or related services. I understand I am responsible for the costs of non-covered services and for the deductible, co-insurance and co-payment charges allowed under federal regulations.

Signature of Patient or Authorized Representative _____ Date _____

215 N Central Ave, Suite 14B
Duluth, MN 55807
www.lakesuperiorphysicaltherapy.com

Phone: 218.625.6300
Fax: 218.724.6700
E-mail: contact@lakesuperiorphysicaltherapy.com