Active Balance Physical Therapy, LLC

1100 Main St *Po Box 1064*Dayton, WY 82836
Phone (307)655-2509 Fax (307)655-2275

# PATIENT REGISTRATION

**(Please print clearly)**

Full Name_____DOB_____
Address_____
City/State/Zip_____
Home Phone _____Cell Phone_____
Social Security #_____Male/Female_____
Email_____
Employer_____Employer Phone #_____

Spouse's Name_____DOB_____
Social Security #_____
Employer_____Employer Phone #_____

## PRIMARY INSURANCE INFORMATION

Insurance Company_____
Policy Holder_____Date of Birth_____
Subscriber #_____Group #_____
Attorney/Case Worker Phone #_____

## SECONDARY INSURANCE INFORMATION

Insurance Company_____
Policy Holder_____Date of Birth_____
Subscriber #_____Group #_____

Referring Provider:_____Reason for visit:_____

**Is this injury accident related?** Yes/No **Car Accident?** Yes/No **Work Related?** Yes/No

## INFORMED CONSENT FOR TREATMENT

**I understand that I am now under the care and supervision of the providers of Active Balance Physical Therapy, LLC. I understand that it is the responsibility of Active Balance Physical Therapy, LLC and its staff to carry out the instructions of the providers. I consent to physical therapy services rendered to me and the expressed or implied instruction of my provider. I understand that any services furnished to me outside of the scope of any instruction, express or implied, of my provider or designee are not performed on behalf of , or at the direction of Active Balance Physical Therapy, LLC.**

## Assignment and Release

**I certify that I, and/or my dependent(s) have insurance coverage with above listed insurance company and assign directly to Active Balance Physical Therapy, LLC all insurance benefits. If any otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges on all insurance submissions. The above named facility may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for the services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is complete or in one year from the signed date below.**

_____ _____

**Signature** **Date**