COMBER PHYSICAL THERAPY FUSION CHIROPRACTIC

PATIENT REGISTRATION FORM

Patient First Name _____ MI ____ Last Name_____ DOB ____/____/____ Gender _____

If previously seen at Comber PT, when? ____/_____/____ For ☐ Physical Therapy ☐ Chiropractic Care ☐ Both

SS # _____ Employment ☐ Part-time ☐ Full-time ☐ Student ☐ Retired Marital Status _____

Mailing Address _____ City _____ State _____ Zip Code _____

Cell Ph (_____)_____ Home Ph (_____)_____ Work Ph (_____)_____

Email Address_____

Emergency Contact Name _____ Phone (_____)_____ Relationship _____

If under 18, Parent/Guardian Name _____ Relationship to Patient _____

How did you hear about us? ☐ Medical Provider ☐ Friend/Family ☐ Returning Patient ☐ Social Media ☐ Consult Card
☐ Personal Injury Referral ☐ WC Case Manager ☐ Internet/Website ☐ Print/Radio Ad ☐ Other _____

Purpose for today's visit ☐ Physical Therapy ☐ Chiropractic Care ☐ Both

Referring Physician _____ Follow-up Date ____/____/____ or ☐ Self-Referral (Direct Access)

Injury/Accident Date ____/____/____ Type of Injury ☐ Auto ☐ Work ☐ Other_____ ☐ No Injury/Unknown

If injury is work related, please provide the following: Employer Name _____

Employer Address _____ Employer Phone (_____)_____

Case Manager Name _____ Phone (_____)_____

Please complete insurance information below, even if insurance card is on file.

Primary Insurance	**Secondary Insurance**
Insurance Company _____	Insurance Company _____
Policy #_____ Group # _____	Policy #_____ Group # _____
Subscriber Name	Subscriber Name
First _____MI ___ Last_____	First _____MI ___ Last_____
Subscriber Birthdate ____/____/____	Subscriber Birthdate ____/____/____
Relationship to Patient _____	Relationship to Patient _____

In the past year, I've received ☐ physical therapy ☐ occupational therapy ☐ speech therapy ☐ chiropractic care from another facility **OR** from home health care. If applicable, please indicate where treatment was received (name of the facility or in-home) to help us determine your remaining insurance benefits. _____

PATIENT REGISTRATION FORM (page 2)

HIPAA ACKNOWLEDGEMENT

Please initial one of the following:

_____ I acknowledge that I have been provided with a copy of the Notice of Privacy Practices.

_____ I acknowledge that I have been provided with a copy of the Notice of Privacy Practices but declined to accept it.

PRIVACY

Please check all acceptable methods of contact. ☐ Home phone ☐ Cell phone ☐ Work phone ☐ Email

Please check your preferred phone number. ☐ Home phone ☐ Cell phone ☐ Work phone

May we leave detailed messages about your appointments or treatment at Comber Physical Therapy with a family member or on your home answering machine/voicemail? ☐ Yes ☐ No

CONSENT TO RELEASE MEDICAL INFORMATION

I authorize Comber Physical Therapy and Fusion Chiropractic, LLC (Comber Physical Therapy), and any of its subsidiaries to discuss information regarding my therapy and patient account with the following individuals:

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship

PATIENT AUTHORIZATION AND CONSENT TO TREAT IN GROUP SETTING

In compliance with Federal HIPAA Regulations, Comber Physical Therapy is committed to protecting your health information and privacy. Our therapists and staff will make every effort to ensure that your protected health information is kept private. However, due to the nature of the open setting of our therapy clinics, certain aspects of your treatment may be performed in the presence of other individuals. In some instances, it is possible that other patients, family members or friends, and our staff will overhear general information relating to your treatment, diagnosis, or benefits. We will do our best to ensure that any private or strictly confidential information is shared with you in a private area.

I authorize treatment by Comber Physical Therapy. (For patients under 18 years of age, the signature of a parent or guardian is required.)

Patient/Guardian signature _____ Date _____

Patient name printed _____

For office use: Registration _____ Date _____

☐ Insurance eligibility ☐ Authorization _____ ☐ MCR cap ☐ Health intake ☐ Financial