REGISTRATION INFORMATION

Patient #____________________________
Diagnosis____________________________
Therapist____________________________
Office Use

Patient____ Date of 1st Appt.________________
Last Name First Middle

Address____City_________________________Zip______________

Cell Phone____________________ Home Phone______________________ Work Phone__________________

Please circle best phone number to reach you during the day!

SS#____________________________ Sex M_____ F_____ Date of Birth________________________________

Marital Status__________________ Email Address:____

Referring Physician____________________________ Primary Care Physician____________________________

Emergency Contact Person____________________________________ Phone ____________________________

Employer

Employer____ Occupation____________________________

Address____ Phone____________________________

Insurance/Billing

Primary Insurance____

Secondary Insurance____

Workman's Comp Claim? No_____ Yes_____ If "yes", Date Injured___________________________________

Auto Accident Claim? No_____ Yes _____If "yes", Date of Accident_______________________________

Consent for and Conditions of Treatment

I, the undersigned, consent to treatment and have insurance coverage with the above named Primary Insurance Company and assign directly to Thunder Bay Therapy & Sports Medicine, (a.k.a. the Provider) all medical benefits, if any, otherwise assigned to me for services rendered. I understand that I am financially responsible for all charges, co-pays and deductibles whether or not paid by insurance, which is the condition of treatment. The Provider reserves the right to charge interest on account balances of 2% per month, retroactive to the date services rendered, when balances remain unpaid 90 days after discharge from Provider. I hereby authorize the Provider to release all information necessary to secure the payment of benefits from the above party I have disclosed to secure payment. **No condition of treatment may be changed unless in writing by the officers of the Provider.**

____ ______________________________________
Signature of Insured/Guardian Date

____ ______________________________________
Person Responsible for Payment (if other than patient) Date