PATIENT REGISTRATION

Patient's Name (last) _____ (first) _____ (m.i.) _____

SSN _____ - _____ - _____ DOB _____ /_____ /_____ Age _____ Sex Male / Female

Patient's Street Address _____ City _____

State _____ Zip _____ Email Address _____

Phone No (home) _____ (work) _____ (cell) _____

Emergency Contact _____ Relationship _____ Phone No _____

Extremity being Treated Left / Right Finger / Thumb / Hand / Wrist / Arm / Elbow / Shoulder

Purpose of visit Illness / Injury / Auto Accident If an Auto Accident, What State? _____

Date of Onset / Injury _____ / _____ / _____ Date of Surgery _____ / _____ / _____

Detailed description of injury/illness _____

_____

Referring Physician _____ Allergies _____

***** Are you the policy holder? YES or NO**

***** If you selected NO please fill out the section below**

Primary Insurance Company Name _____

Policyholder's Name _____ DOB _____ / _____ / _____

Address (if different than patient) _____

Phone No _____ Policyholder's relationship to Patient Spouse / Parent / Other

Secondary Insurance Company Name _____

Policyholder's Name _____ DOB _____ / _____ / _____

Address (if different than patient) _____

Phone No _____ Policyholder's relationship to Patient Spouse / Parent / Other

*****Is this a work related injury? YES or NO**

*****If you selected YES, please fill out the section below**

Workers' Compensation

Employer at the time of injury _____ Contact Person _____

Employer address _____ Phone No _____

WC Insurance Co _____ Claim No _____

Adjuster _____ Phone No _____ Email _____

Nurse CM _____ Phone No _____ Email _____

I hereby voluntarily consent to receive treatment for myself or my dependent for my diagnosis according to my treatment plan. I understand that a properly credentialed clinician at Charleston Hand Therapy Center and in accordance with the law will perform my treatment. I further understand that I may rescind my consent at any time and will be informed of the potential consequences of that decision.

I, the undersigned, authorize the release of any medical information relating to all claims for benefits submitted on behalf of myself or my dependent. I further agree and acknowledge that my signature on this document authorizes Charleston Hand Therapy Center to submit claims for services rendered or to be rendered, without obtaining my signature on each and every claim submitted for myself or my dependent. I hereby assign directly to Charleston Hand Therapy Center all insurance payments, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred. If my account is turned over for collection, I agree to pay all costs of collection, including a reasonable attorney fee. Any insurance benefits quoted are not a guarantee of payment. Charleston Hand Therapy Center encourages each patient to verify their insurance coverage and benefits. Photo static copy of this authorization shall be considered as effective and valid as the original.

Patient/Responsible Party _____ Date _____ / _____ / _____