PATIENT REGISTRATION

Patient's Name (last) _____ (first) _____ (initial) _____

DOB _____ /_____ /_____ Age _____ Sex M / F Marital Status S M D W SSN _____- _____- _____

Patient's Address _____

City _____ State _____ Zip _____

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

Patient/Responsible Party Employed By _____ Phone No _____

Employer Address _____

Responsible Party _____ Relationship to Patient _____

Responsible Party Address _____

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

Emergency Contact _____ Relationship _____ Phone No _____

Purpose of visit: Illness / Injury / Auto Accident Description_____

_____

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

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

Referring Physician_____Allergies_____

Primary Insurance Company Name _____

Subscriber's Name _____SSN_____-_____-_____

Subscriber's DOB _____ /_____ /_____ Patient's Relationship to Subscriber Spouse / Child / Self / Other

Subscriber's Employer Name_____ Phone No _____

Subscriber's Employer Address _____

Secondary Insurance Company Name (if any) _____

Subscriber's Name _____SSN_____-_____-_____

Subscriber's DOB _____ /_____ /_____ Patient's Relationship to Subscriber Spouse / Child / Self / Other

Subscriber's Employer Name_____ Phone No _____

Subscriber's Employer Address _____

Workers' Compensation Company Name _____

Employer at the time of injury _____ Contact Person _____

Adjuster's Name _____ Phone No _____

Case Manager's Name _____ Phone No _____

Claim No _____ Do you have an attorney? Y / N

Attorney Name _____ Phone No _____

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 understand and acknowledge that Charleston Hand Therapy Center may charge a $25 fee for appointments missed or cancelled without notification 24 hours prior to my scheduled appointment time.

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 benefits, 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. Photo static copy of this authorization shall be considered as effective and valid as the original.

Patient/Responsible Party _____ Date _____