



Registration Form

First Name: _____ Last Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status: _____

Email: _____ Returning Patient YES NO

Employer: _____ Occupation: _____

Address: _____ City/State: _____ Zip: _____

Work Phone: _____ Full Time or Part Time or Seasonal or Temporary (circle one)

Permission to contact: YES NO If so, check all that apply? Home Cell Work Email

Injured Body Part: _____ Referring Dr: _____ Date of Injury: _____

Workman's Comp Case: YES NO Motor Vehicle Accident Case: YES NO

Emergency Contact Name: _____ Phone: _____

Who referred you to our office? _____

Privacy Notice: Under the HIPAA Privacy Policy we are required by law to maintain the privacy of your medical records. If you would like a detailed description of this policy please see the front desk. If you are declining a copy of the HIPAA Privacy Policy please sign below.

(Signature of Patient/Guardian)

Assignment & Release

I assign directly to North Suburban Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all medical information necessary to secure the payment of all my insurance submissions. I am responsible for all non sufficient fund checks returned with an additional \$35 fee.

I understand that I am undergoing physical therapy treatment at North Suburban Physical Therapy and I hereby authorize my consent for treatment.

Signature of Patient/Guardian

Date