Patient Registration Form

Name: Last_____ First_____MI____
Home Address_____
City_____ State_____ Zip_____
Phone_____Email_____
Birth Date_____
Sex M/F
Marital Status: Married/Divorced/Single
Spouse's Name_____ Spouses phone number _____
Employer: (If you are under 18 years of age list your parents' employers here and under Spouse employer)
Company Name_____
Address_____Zip_____
Work Phone:_____Work Fax_____
Spouse's Employer: Company Name_____
Address_____Zip_____
Work Phone_____Work Fax_____
Referred by_____
Address if known_____
Zip_____Phone_____Fax_____
Diagnosis and/or description of problem _____
_____
Date Began_____ Claim # if Applicable_____
Previous Serious Illness or Injury _____
_____
Known Allergies_____
Contact in Case of Emergency: Name_____
Relation_____Phone Number_____
How did you hear about Finesse Physical Therapy? Doctor, friend/relative, yellow pages, employer, other_____
Please indicate method of payment for treatment: Cash, Check, Credit Card, insurance
Insurance Company Name:_____Policy Number_____

Signature_____Date_____

Billing Policy
Release and Authorization

Finesse Physical Therapy P.L.L.C.

____I authorize Finesse Physical Therapy to treat me (my child) and to release medical or other information as necessary to receive payment or make referrals to other health care professionals.

____I understand that payment is required at time of service.

____I understand that some insurance companies require preauthorization for treatment or have reimbursement limits.

____I understand I am responsible for knowing and meeting the requirements of my insurance plan.

____I understand that Dr. Jodi Knable and Finesse Physical Therapy ARE NOT medicare providers and all charges are my responsibility.

____I understand that I cannot submit my expenses to Medicare.

____I release Finesse Physical Therapy, and Jodi Knable, DPT, from all liability, except in the case of gross negligence.

____I understand that any cancellations less than 24 hours before my appointment will result in me being charged the full amount of my visit.

Signature_____Date_____