ORION PHYSICAL THERAPY | ACTIVE ORTHOPEDICS

New Patient Registration

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	GENDER

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL	EMAIL

MARITAL STATUS	EMPLOYMENT STATUS
☐ Single ☐ Married ☐ Other	☐ Employed ☐ Student ☐ Retired ☐ N/A

EMPLOYER/SCHOOL NAME	TITLE/POSITION	WORK PHONE

REFERRING PHYSICIAN

LAST NAME	FIRST NAME	LOCATION (CITY/TOWN)	PHONE NUMBER

EMERGENCY CONTACT

LAST NAME	FIRST NAME	RELATIONSHIP TO PATIENT

HOME PHONE	WORK PHONE	CELL PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	CARDHOLDER DATE OF BIRTH

SECONDARY INSURANCE COMPANY	CARDHOLDER DATE OF BIRTH

RESPONSIBLE PARTY STATEMENT

I understand that my insurance policy is a contract between myself and my insurance company. As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I hereby assign all medical benefits to which I am entitled to Orion Physical Therapy/Active Orthopedics in the event they file insurance on my behalf. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with collection of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Orion Physical Therapy/Active Orthopedics as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

AUTHORIZED SIGNATURE DATE

By signing this document, I authorize Orion Physical Therapy/Active Orthopedics to service my account or collect any amount I may owe. Orion Physical Therapy/Active Orthopedics, A third party billing department and/or a debt collection agency may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which may result in charges to me. Additionally, I authorize contact via text message or emails, using any email address I provide. Methods of contact may include using prerecorded/artificial voice message and/or use of an automatic dialing device, if available.

AUTHORIZED SIGNATURE DATE

How did you hear about us? ☐ Physician ☐ Family/Friend ☐ Newspaper ☐ Yellow Pages ☐ Other

Do you want to receive company updates/news via email? ☐ Yes ☐ No