BERGENFIELD PHYSICAL THERAPY & PAIN MANAGEMENT

135 Bloomfield Ave., Suite C, Bloomfield, NJ 07621 PHONE: 973-429-0045 FAX: 973-429-8161

PATIENT REGISTRATION

PLEASE PRINT CLEARLY / ENCIRCLE

Last Name: _____ First Name: _____ MI _____

Home Address: _____ City: _____ State:_____ Zip: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

SS #: _____ Driver's License: _____

SEX: Male / Female MARITAL STATUS: Married / Single / Separated/Widowed

STUDENT STATUS: Full time / Part time

EMPLOYER'S INFORMATION:

Employer's Name: _____

Employer's Address: _____ City: _____ State:_____ Zip: _____

Work Phone: _____ STATUS: Full time/Part time unemployed/ Self Employed/ Retired

REFERRING LAWYER: (if applicable) _____ Phone: _____

Address: _____ City: _____ State:_____ Zip: _____

PRIMARY INSURANCE INFORMATION:

Insurance Name: _____

Billing Address: _____City: _____ State: _____ Zip: _____

Ins. Phone No. _____ Policy holder's Name: _____

Policy No. _____ Group No. _____

Annual Deductible: $_____ Co-pay: $_____ Capitated Plan: $ _____

Percentage of Service: 50/50 60/40 70/30 80/20 90/10 100% Other: _____

Treatment Authorization From: _____ Authorized Number of Visits: _____

Authorization / Claim Number:_____ Adjuster:_____

SECONDARY INSURANCE INFORMATION: (if applicable)

Insurance Name: _____

Billing Address: _____City: _____ State: _____ Zip: _____

Ins. Phone No. _____ Policy holder's Name: _____

Policy No. _____ Group No. _____

Annual Deductible: $_____ Co-pay: $_____ Capitated Plan: $ _____

Percentage of Service: 50/50 60/40 70/30 80/20 90/10 100% Other: _____

Treatment Authorization From: _____ Authorized Number of Visits:_____

Authorization / Claim Number:_____ Adjuster:_____

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EMERGENCY CONTACT:

Spouse's Name: _____ Work Phone: _____ Cell #: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Name of Land lord:_____ Phone :_____

Consent for treatment

I voluntarily consent to the rendering of care, including treatment and performance of therapeutic procedure. I understand that I am under the care and supervision of the attending Licensed Physical Therapist.

Authorization to release form

I hereby authorize the release of any information pertinent to my case to any insurance company, medical providers or lawyer involve in this case

I authorized Bergenfield Physical therapy to initiate complaint to Insurance Commissioner for any reason on my behalf.

Assignment of Benefits

I hereby assign direct payment to Bergenfield Physical therapy and Pain management for the services rendered under their direct supervision. I understand that I am financially responsible for any balance not covered by my insurance, regardless of my insurance status. All information on the registration sheet has been completed. I certify that this information is true and correct to the best of my knowledge and will be responsible in notifying your office on any changes in my status on the above information. A photocopy of this Assignment shall be considered as effective and valid as the original

Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care as a medical provider our relationship is with you, and not with your insurance company. We will process your claim for payment. While the filling of insurance claim is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered.

1. Applicable Payment for services is due at the time services are rendered, unless payment arrangements have been approved in advance by the billing department. We accept cash, checks and credit cards
2. You are responsible for rejected treatments dates and/or amount reflected in the Explanation of benefits given by your insurance company.
3. A charge of $75 may also be made for broken appointments and cancelled appointments without 24 hours advance notice.
4. Returned checks and balances older than 30 days on the last check received are subject to additional collection fee and interest charge of 1.5 % monthly (18% per annum).

Patient Signature: _____ Date Signed: _____

Patient (if minor): _____ *Date signed:* _____

Privacy Practice Acknowledgement

I have received the Notice of privacy Practice and have been provided an opportunity to review it.

Name _____ Birth date: _____

Signature:_____Date:_____