DISCOVERY
PHYSICAL THERAPY

REGISTRATION CONSENT

NAME: _____ SEX: ____ male ____ female

ADDRESS_____
Street City State Zip

PHONE#_____ CELL # _____ WORK # _____

BIRTHDATE_____ S.S.#_____

REFERRING PHYSICIAN _____

DATE OF ONSET _____ EMPLOYER _____

PRIMARY INSURANCE _____ _____ INSURED BIRTHDATE _____

SECONDARY INSURANCE _____ INSURED BIRTHDATE _____

IN ORDER TO BILL YOUR INSURANCE WE MUST HAVE A COPY OF YOUR INSURANCE CARD(S).

ON-THE-JOB INJURY/AUTO ACCIDENT INFORMATION

_____ WORK _____ AUTO DATE OF INJURY _____ STATE OF INJURY _____

CLAIM # _____

CLAIMS MANAGER/ADJUSTOR _____ PHONE # _____

BILLING ADDRESS _____

HAVE YOU RECEIVED PHYSICAL THERAPY THIS YEAR? Yes_____ No_____ If yes where? _____

EMERGENCY CONTACT _____ PHONE NUMBER _____

NAME OF PERSON WITH WHOM WE ARE ALLOWED TO DISCUSS BILLING/TREATMENT INFORMATION:

NAME_____ RELATIONSHIP_____

CONTINUED ON NEXT PAGE »

P.O. BOX 0897 ▮ 27 COLWELL STREET ▮ PORT HADLOCK, WA 98339 ▮ TEL 360.385.9310 ▮ FAX 360. 379.8826

Cancellation~No Show Policy:
We require 24 hours' notice if you need to cancel an appointment to allow us to spend that time with another patient. **Cancellation/no-show fee: $50**

Consent to Non-Encrypted Email Contact and Transmittal of Private Health Information

I hereby consent to communication via non-encrypted email and/or the transmittal of protected private health information via non-encrypted email.

Email ADDRESS: _____

_____ _____
Signature of Individual or Personal Representative Date

_____ _____
Signature of Witness Date

- **Release of medical records:**
  I authorize the release of my medical records to my physicians/primary care provider or insurance company: _____ (Please initial) *

- **I have reviewed a copy of the Notice of Privacy Practices:** _____ (Please initial)*

- I hereby authorize my insurance company to make payments directly to Discovery Physical Therapy. **I will be responsible for verifying my insurance benefits and paying any amount that my insurance does not cover.** _____ (Please initial)*

I will inform my therapist of any condition that would limit my ability to have an evaluation or to be treated. I hereby request and consent to the evaluation and treatment to be provided by the physical therapists and physical therapy assistants of Discovery Physical Therapy.

SIGNATURE_____**DATE**_____
(If you are under 18, a parent or guardian must sign for you.)