MIKE KELO
PHYSICAL THERAPY
let the healing begin

PATIENT REGISTRATION

Welcome To Our Office...
PLEASE PRINT CLEARLY

For Office Use Only
☐ *New Patient* ☐ *Update*
MR # _____ NBS # _____

PATIENT NAME _____ Sex☐M☐F **DOB** _____ **SS #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Phone #'s: Home _____ **Work** _____ **Cell** _____ **Email** _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

NAME OF RESPONSIBLE PARTY _____ **DOB** _____ **SS #** _____

Address _____ City _____ State _____ Zip _____

Phone #s: Home _____ **Work** _____ **Cell** _____

Employer _____

Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT _____ Relationship _____

Address _____ **Contact's Phone #** _____

PRIMARY CARE PHYSICIAN _____ **Office Phone #** _____

Impairments: ☐ Vision ☐ Hearing ☐ Mobility ☐ Other _____ _____ ☐ N/A Primary Language _____

HEALTH INSURANCE COVERAGE – *To be completed by ALL patients.*

(In the case of worker's compensation, this information will only be used if your case is denied.)

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company Name		
Insurance Company Address-City/State		
ID or Policy #		
Group #		
Effective Date		
Insurance Phone #		
Insurance Fax #		
Policy Holder's Name		
Policy Holder's Date of Birth		
Policy Holder's SS #		
Relationship to Patient		
Policy Holder's Employer		

(OVER)

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Please complete this section if your illness/injury is Worker's Compensation based.

Employer's Name _____

Employer's Address _____

Contact Person _____ Employer's Telephone #_____

PATIENT AUTHORIZATION FOR TREATMENT, CLAIMS & PAYMENT

Thank you for selecting Mike Kelo Physical Therapy as your health care provider. We are committed to providing you with the best possible medical care. Following is an authorization for treatment, claims payment and review of policies which we require you to sign prior to any treatment.

Authorization for Medical Treatment: I authorize and consent to healthcare services or supplies including, but not limited to, diagnostic procedures, injections, therapy and medical treatment at and by Mike Kelo Physical Therapy. I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services. I have the right to refuse treatment and/or medicines after my physician has given me adequate explanation.

Financial: In consideration of healthcare services provided to me by Mike Kelo Physical Therapy for this and all subsequent services, I agree to pay Mike Kelo Physical Therapy in accordance with its regular rates and terms of payment. I assume full responsibility for payment of all charges associated with the healthcare services provided to me, including any portion not paid by insurance carriers, worker's compensation or any third party. Such unpaid charges may include, but are not limited to, copayment, deductible, coinsurance amounts and or services considered by my carrier to be non-covered. Should my account be referred for collection, I agree to pay all collection costs and expenses, including attorney's fees. **As required by your insurance carrier, you are responsible for obtaining any necessary referral or authorization if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. You are required to pay any mandatory copayment at the time of service.**

Medicare Lifetime Signature (if applicable): I authorize any holder of medical or other information about me and their agents to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and I request payment under Medicare be made to the physician, provider or other supplier of services or supplies furnished by the physician, provider or other supplier.

Assignments of Benefits: In consideration of healthcare services provided to me by Mike Kelo Physical Therapy for this and all subsequent services, I hereby assign to Mike Kelo Physical Therapy any and all rights, benefits and claims I may have under any policy of insurance (major medical, automobile, liability, workers' compensation, and any other) and the proceeds from any claim that I may have for injuries. I permit a copy of this authorization and assignment to be used in place of the original. Such assignment hereby authorizes direct payment to Mike Kelo Physical Therapy under and/or from any such policy of insurance or proceeds.

_____ _____

Patient's or Financially Responsible Party's Signature **Date**

_____ _____

Legal Guardian's or Power of Attorney's Signature **Date**

_____ _____

Witnessed by Mike Kelo Physical Therapy Representative **Date**