PATIENT REGISTRATION FORM

AOSPT Rehabilitation Services
Licensed Physical Therapists, Occupational Therapists & Speech Language Pathologists

Hammonton: _____ _____ Therapist: _____
Mays Landing: _____ : _____ Eval Date: _____
Vineland: _____ Heritage: _____
Med B: _____ Other: _____
Glassboro _____ _____

Name: _____ Date of Birth: _____

Address: _____ Phone Number: _____

_____ Work/Cell Number: _____

Sex: M/F _____ Injury Work Related: ___Yes ___No Auto Related: ___Yes ___No

Date of Accident/Injury: _____ Date of Surgery: _____

Patient Social Security Number: _____ Diagnosis: _____

Referring Physician: _____ Primary Physician: _____

Employer Name: _____ Phone Number: _____

Employer Address: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Address: _____ Policy Holder's Social Security: _____

_____ Phone Number: _____

Relationship to Patient: (01) Self (02) Spouse (03) Parent (04) Other: _____

Primary Insurance: _____ Phone Number: _____

Address: _____ Claim/Policy: _____

_____ Adjuster: _____

Secondary Insurance: _____ Phone Number: _____

Address: _____ Claim/Policy: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Assignment of benefits and medical release: I irrevocably assign to Atlantic Orthopedic and Sports Physical Therapy and Mid-Atlantic all of my rights and benefits under any insurance contracts for payment for services rendered to me by AOSPT or Mid-Atlantic. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by AOSPT to be released to AOSPT. I authorize AOSPT to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to AOSPT. I irrevocably authorize AOSPT to act on my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfication and I understand its nature and effect.

Patient Signature: _____ Date: _____

or

Authorized Person: _____ Relationship: _____