ADVANTAGE SPORTS MEDICINE & PHYSICAL THERAPY, INC.
245 North Street, Stoneham, MA 02180
Ph: 781-438-7221 Fx: 781-438-7208 email: advantagesportsmedicine@comcast.net

PATIENT REGISTRATION

Area of Injury to be treated_____ **Today's Date _____**

Auto _____ WComp ____ Other Ins _____ Date of Injury _____

Name _____
First MI Last

Address _____ _____
Street PO Box Apt #

Address _____
City State Zip

Home Phone _____-_____-_____ Work Phone_____-_____-_____ Cell Phone_____-_____-_____

Male ___ Female ___ Marital Status M S D E-Mail: _____

Date of Birth _____ Emergency Contact: (name, phone)_____

Employer Information – Complete if Work Comp claim **Occupation**_____

Employer _____

Address _____ Phone _____
Street City ST Zip

Physician Information

Primary Care Physician Name _____

Referring Physician Name _____ _____

Have you had physical therapy before? ___ No ___ Yes If yes, when? _____

Primary Health Insurance Information **Insurance Carrier** _____

Member ID#_____ Group Number _____

Primary Insured Name _____ Insured Date of Birth _____

Relationship to patient _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____
Street City ST Zip

Secondary Health Insurance Information **Insurance Carrier** _____

ID#_____ Group Number _____

Primary Insured Name _____ Insured Date of Birth _____

Relationship to patient _____ Insured Phone # _____

Insured Address if Different from Patient:

Address _____
Street City ST Zip

WComp / Auto Information

Claim # _____

Insured Name _____ Insured Date of Birth _____

Attorney Name _____

Address _____
Street City ST Zip

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CONSENT TO TREATMENT

I hereby authorize the professional staff at **Advantage Sports Medicine & Physical Therapy, Inc.** to examine and treat me with physical therapy for the injury I have been referred here for or referred myself to.

Patient Signature _____ Date _____

Patient Printed Name _____ Staff Witness Signature _____

Parent or Guardian Signature (if under 18) _____ Date _____

Parent or Guardian Printed Name _____ Staff Witness Signature _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: Advantage Sports Medicine & Physical Therapy, Inc. for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **Advantage Sports Medicine & Physical Therapy, Inc.** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 1 year from the date the last bill is collected.

HIPPA REGULATIONS: A photocopy of this Assignment shall be considered effective and valid as the original.
I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Patient Name (Printed) Date _____ Patient Signature _____

Parent or Guardian (Printed) Relationship _____ Parent or Guardian Signature _____

Witness _____ Date _____

How did you hear about us? _____

_____

If you are a returning patient, what brought you back to us? _____

_____

Are you currently, or have you recently had any home health services? ___ No ___ Yes
If yes;
Are you still receiving services? ___ No ___ Yes
If no, when were you discharged? _____