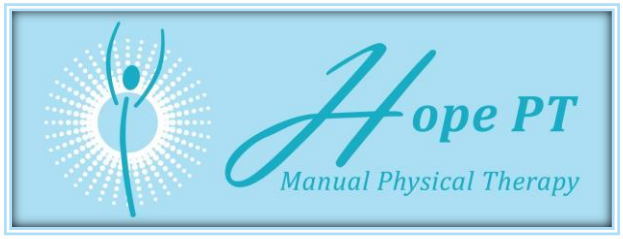

Relieving Pain. Restoring Function. Renewing Hope.

10412 Allisonville Rd - Ste 112
Fishers, IN 46038
Phone: 317-288-7763
Fax: 317-288-7765
E-Mail: info@hope-pt.com
Web: www.hope-pt.com

PATIENT REGISTRATION

Name: _____

Address: _____

City/State/Zip: _____

Home Phone: _____

Mobile Phone: _____

E-mail: _____

Emergency Contact: _____

Relationship to Patient: _____

Please be advised that failure to cancel/reschedule an appointment 24 hours in advance will result in automatic $45.00 cancellation fee.

DOB (Date of Birth)**:** _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Other

Student: ☐ Full-Time ☐ Part-Time

Employer: _____

Reason for Clinic Visit: _____
(e.g. Neck, Shoulder, Back, Leg Pain)

Direct Access ☐* *or* **Medical Referral** ☐*
*Your insurance may require Referral or Precertification

Referring Practitioner ☐ _____
Primary Practitioner ☐ _____

Insurance / Billing

Self-Pay	☐	Cash Rate. Insurance is **not** filed.	Patient is responsible for *full payment at time of service.*
Insurance	☐	Billing Rate. Insurance is filed.	Patient is responsible for *Deductible, Co-Pay, Co-Ins.*
Primary	☐	Medicare	☐ Original Medicare **(Part B)** Outpatient + Supplement Plan. Medigap Carrier:
			☐ Replacement Medicare **(Part C)** Advantage Plan. Carrier:
	☐	Ins. Co.: _____	
Secondary	☐	Ins. Co.: _____	

Work Comp / Auto / Accident

IS YOUR INJURY JOB RELATED?	**YES**	**NO**	Do you have an open claim? Yes No Claim # _____
			Claims Manager: _____ Telephone: _____
			Claims Address:
INJURY DUE TO MOTOR VEHICLE ACCIDENT?	**YES**	**NO**	Where did accident occur? In which State: _____
Are You Covered by PIP (Personal Injury Insurance)?			PIP Adjuster: _____ Telephone: _____
			PIP Billing Address: _____

CONSENT / ASSIGNMENT and RELEASE

CONSENT: My diagnosis and treatment plan will be discussed during my appointment and I understand that I have the right to question and/or refuse any treatment offered.

ASSIGNMENT AND RELEASE:

For insurance coverage, I, the undersigned, certify that I (or my dependent) have (has) insurance coverage and assign directly to **Hope PT LLC** all insurance benefits, and if any otherwise payable to me, for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **Hope PT LLC** to release information when necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. The information I have provided above is accurate and complete.

_____ _____
(Signature) **(Date)**