Benchmark Physical Therapy & Wellness Center LLC

Registration Form (PLEASE PRINT)

Patient Information

Name _____ Date_____

Last Name First Name Middle Initial

Address_____

Street City State Zip code

Home Phone # (_____) _____Cell (_____) _____Work (_____) _____

Sex ☐M ☐F Age_____ Date of Birth _____/_____/_____ SS# _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Driver's license#_____

Patient Employed by _____ Occupation_____

Business Address_____

Street City State Zip code

In case of emergency who should be notified? _____

Relationship to patient _____ Phone (_____) _____

Primary Doctor _____ Phone (_____) _____

Whom may we thank for referring you to our facility? _____

Primary Insurance

Insurance Company_____

Person responsible for account _____ Relation to patient_____

Secondary Insurance

Is patient covered by additional insurance? ☐Yes ☐ No

Insurance Company_____

Assignment and Release

I, the undersigned, have insurance coverage with the above stated insurance company and assign directly to Benchmark Physical Therapy & Wellness Center LLC all medial/insurance benefits if any, otherwise payable to Benchmark Physical Therapy & Wellness Center LLC for services rendered. I understand that I am financially responsible for any and all charges whether or not paid by insurance, settlement or otherwise. I hereby direct any attorney or insurance company to release immediately any and all medial/insurance benefits payable on my behalf to Benchmark Physical Therapy & Wellness Center LLC. I hereby authorize Benchmark Physical Therapy & Wellness Center LLC to release all information necessary to secure the payment of benefits. I realize I am financially responsible for non-covered services. I authorize the use of this signature on all my insurance submissions. I hereby give permission to the therapist and staff to administer treatment and perform such procedures as deemed necessary in the diagnosis and/or treatment of my condition. Accounts past due are subject to collection cost and attorneys fees which I agree to pay.

□ I consent to care and treatment for the above listed patient, who is a minor, and declare I have guardianship over.

ALL ACCOUNTS OVER 30 DAYS PAST DUE ARE SUBJECT TO 1 ½% MONTHLY FINANCE CHARGE

Responsible Party Signature Relationship Date