Benchmark Physical Therapy & Wellness Center LLC

Registration Form (*PLEASE PRINT LEGIBLY*)

Patient Information

Name _____

Last Name First Name Middle Initial

Address_____

Street City State Zip code

Home Phone# (_____) _____ Cell# (_____) _____ (Please Circle Primary Number)

Email Address for Appointment Reminders:_____

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

☐Single ☐Married ☐Partnership ☐Widowed ☐Separated ☐Divorced

Patient Employer: _____

Occupation_____Work# (_____) _____

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 _____ Relationship to patient_____

Secondary Insurance

Is patient covered by additional insurance? ☐Yes ☐ No

Insurance Company_____

Benchmark Physical Therapy and Wellness Center, LLC reserves the right to remove any/all appointments if a patient cancels (with less than 24 hours notice) or "no-shows" three consecutive appointments. This policy is in place out of respect for our therapist's and our client's time. Thank you for your consideration and understanding.

There will be a $25 fee for cancellations less than 24 hours in advance of scheduled appointment. The only exception to this policy is severe weather. Signing below acknowledges agreement to pay this fee at the time of the next scheduled appointment.

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. As a courtesy, this office will call your insurance to check your therapy benefits. Please note that any quote of benefits given to Benchmark Physical Therapy by your insurance company is not a guarantee of payment. This office encourages its patients to call their insurance company with any questions regarding coverage.** 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.

Patient Signature *or* Responsible Party Signature (if patient is a minor) Relationship to minor **Date**