GORDONPT Physical Therapy

70 Main Street Suite 201
North Andover, MA 01845
P: 978-273-2863
F: 508-928-2265

Patient Registration

(Please write legibly)

Today's Date:	Date of appointment:	Reason for treatment:	☐ Self-Pay ☐ Insurance ☐ Auto ☐ Work Comp
First Name, Middle Initial:		Last Name:	
Date of Birth:	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Divorced	Minor: ☐ Yes ☐ No
Street Address:		City:	State: / Zip:
Home Phone:	Cell Phone:	Work Phone:	Email:
Please Remind me of appointments via: ☐ Phone ☐ Email	Emergency Contact:	Phone #:	Relation:
Employer:		Occupation:	
Employer Address:		City:	State: / Zip:
Primary Care Physician (*first, last*):	Phone #:	Location:	Have you had PT before? ☐ Yes ☐ No When?
Referring Physician (*first, last*):	Phone #:	Location:	
Primary Health Insurance:	Member #:		Group #:
Insured's Name:		Insured Date of Birth:	Relation:
Secondary Health Insurance:	Member #:		Group #:
Insured's Name:		Insured Date of Birth:	Relation:
Are you currently, or have you recently received Home Health services? ☐ Yes ☐ No		If yes are you still receiving treatment? ☐ Yes ☐ No If no, when were you discharged?	
Auto/Accident/Worker Comp Insurance:		Claim#:	Date of Injury:
Adjuster Name:		Phone #:	Fax#:
Attorney Name:		Phone:	Fax#:
May we send you our newsletter? ☐ Yes ☐ No	How did you hear about us?		

Consent to Treatment

I hereby authorize the profession staff at **Gordon Physical Therapy** to examine and treat me with physical therapy for the Injury I have been referred here for or referred myself to.

_____ _____
Patient Signature **Date**

_____ _____
Printed Name **Date**

_____ _____
Parent/Guardian Signature (*if under 18*): **Date**

_____ _____
Parent/Guardian Printed Name: **Date**

HIPAA Regulations

I understand that **Gordon Physical Therapy** complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used 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 my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of last bill collected.

_____ _____
Patient Signature **Date**

_____ _____
Printed Name **Date**

_____ _____
Parent/Guardian Signature (*if under 18*): **Date**

_____ _____
Parent/Guardian Printed Name: **Date**

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies(S) _____

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to **Gordon Physical Therapy** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. 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.

_____ _____
Patient Signature **Date**

_____ _____
Printed Name **Date**

_____ _____
Parent/Guardian Signature (*if under 18*): **Date**

_____ _____
Parent/Guardian Printed Name: **Date**