GORDONPT Physical Therapy

70 Main St, Suite 201
N Andover, MA 01845
P: 978-315-2500
F: 978-315-2501

Patient Registration

Today's Date: _____ Date of 1st Visit: _____ Diagnosis/Reason for Treatment: _____

Returning Patient? ☐ Yes ☐ No Payment Type: ☐ Self Pay ☐ Insurance ☐ Auto ☐ Workers Comp

Patient Name: _____ **Date of Birth**: _____

Street Address: _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Best Way to Contact: ☐ Cell Phone ☐ Home Phone ☐ Email

Emergency Contact Information

Emergency Contact Name: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Physician Information

Referring Physician: _____ Office Phone: _____

Primary Care Physician: _____ Office Phone: _____

Have you had physical therapy before? ☐ Yes ☐ No If yes, when/where? _____

Insurance Information

Primary Insurance: _____

Member ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Subscriber Phone: _____

Subscriber Address (if different from patient): _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance: _____

Member ID#: _____ Group #: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Relationship to Patient: _____ Subscriber Phone: _____

Subscriber Address (if different from patient): _____ Apt/Unit: _____

City: _____ State: _____ Zip Code: _____

Auto & Workers Comp

Insurance: _____ **Claim #**: _____

Date of Injury: _____

Adjuster Name: _____ **Adjuster Phone**: _____

Adjuster Fax: _____ Adjuster Email: _____

Attorney Name: _____ Attorney Phone: _____

Attorney Address: _____ Suite/Unit: _____

City: _____ State: _____ Zip Code: _____

Attorney Phone: _____ Attorney Fax: _____

Attorney Email: _____

Employer Information *(For all Worker's Comp)*

Employer Name: _____ Employer Phone: _____

Employer Address: _____ Suite/Unit: _____

City: _____ State: _____ Zip Code: _____

Other

How did you hear about us? _____

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

Consent to Treatment

I hereby authorize the professional 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

_____ _____
Patient Printed Name Staff Witness Signature

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

_____ _____
Parent or Guardian Printed Name Staff Witness Signature

Assignment of Benefits and Release of Medical Information
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: Gordon Physical Therapy (Assignee) 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 hereby release Assignee, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives. By signing this Assignment of Benefits and Release of Medical Information I acknowledge the following: I am aware and understand that this authorization will not be used unless the above named insurance company(s) or their designated representatives request records of information for reimbursement purposes; or seek to take action reference payment for treatment services, I agree to participate and assist Assignee or its designated representatives with any appeal process necessary to collect payments for services rendered, I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof, I understand Assignee is acting in filing for insurance benefits assigned to myself and it can assume no responsibility for guaranteeing payment of any charges from the insurance company(s), I understand a firm contracted by Assignee for billing and collection purposes may do billing, I understand that Assignee is appointed by me to act as my representative and on my behalf in any proceeding that may be necessary to seek payment from my insurance carrier which includes receiving a copy of my insurance plan's documents, I agree that should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment, I agree that Assignee shall be entitled to the full amount of its charges without offset.

HIPAA REGULATIONS

I understand that Gordon Physical Therapy complies with HIPAA 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 90 days from the date the last bill is collected.

I have received a copy of the Notice of Information Practices. _____
Initial

A photocopy of this Assignment shall be considered effective and valid as the original. _____
Initial

_____ _____
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