NEW PATIENT REGISTRATION FORM

Last Name | First Name | MI

Home Phone Number | Cell Phone Number | Work Phone Number

Home Address | Apt. # | City | State | Zip Code

Patients Social Security # | Patients Date of Birth | Student Full Time ( ) Part Time ( )

E-Mail Address | Contact in case of emergency

Spouse Name | Social Security # | DOB

Spouse Employer / address / phone

INSURED'S INFORMATION (if different from above)

Last Name | First Name | MI | Home Phone Number

Home Address | Apt. # | City | State | Zip Code

Insured's Employer | Work Phone Number

Insured's Social Security # | Insured's Date of Birth

Responsible Party Statement / Assignment of Benefits

As the Responsible Party I Agree That All Charges That Are Not Directly Paid By My Insurance Company Will Be My Responsibility

I Hereby Assign All Medical Benefits To Which I Am Entitled To Peak Physical Therapy In The Event They File Insurance On My Behalf. I Understand That I Am Financially Responsible For All Charges Whether Or Not Paid by Said Insurance. In The Event My Account Becomes Delinquent And Is Therefore In Default Of Payment I Accept Responsibility For The Principal Amount Owing As Well As All Attorney's Fees And All Court Costs And Any Additional Legal Fees Associated With The Recovery Of This Debt. Interest May Be Charged At A Rate Of 1.5 % Per Month Or 18% Annually For Unpaid Balances Over 60 Days Old. I Hereby Authorize Said Assignee To Release All Information Necessary To Secure The Payment Of Said Benefits

Authorized Signature | Date

Authorization To Release Medical Information/Consent To Treatment

I Do Hereby Consent To Such Treatment By The Authorized Personnel Of Peak Physical Therapy As May Be Dictated By Prudent Medical Practice By Illness, Injury, Or Condition. This Consent Is Intended As A Wavier Of Liability For Such Treatment Excepting Acts Of Negligence. A Copy Of This Assignment Shall Be Considered As Effect And Valid As The Original

Authorized Signature | Date