mountain center
physical therapy • performance fitness • functional health

Patient Registration

Patient Name_____
Last First MI

Mailing Address_____
City_____State____Zip Code_____
Name of Parents (if a minor)_____

Date of Birth _____
Home Phone_____ Male___ Female___
Work Phone _____Marital Status_____
Cell Phone_____
Social Security #_____
Email _____
Employer:_____

Emergency Contact: Name_____Phone #_____Relationship_____

Let us know how you heard about and chose Mountain Center Physical Therapy? (Please circle)

Sign
Radio

Personal Choice Former Mountain Center Client Website
Friend Family Member Athletic Trainer Facebook
Newspaper Referring Physician Primary Care Physician

Primary Care Physician_____ Date Last Seen_____

Physician who referred you here_____ Date Last Seen_____
(if different than primary care doctor)

Are you choosing to use your personal health insurance? If so, please provide us with your insurance card.

Primary Insurance Plan _____ Subscriber's Name_____ DOB _____
Is your injury related to an **Auto Accident** or **Worker's Compensation claim?**

Authorization to Release Medical Information: I hereby authorize Mountain Center (MC) to release any and all information regarding my care, as requested by my Insurance Company and/or my physician(s).
Authorization of Insurance Benefits: I hereby authorize payments from my insurance company and/or other responsible party to go directly to MC. I agree that if there are any charges over and above those which are paid by my insurance company, it is my responsibility to provide payment for these charges.
Please note: Accounts older than 6 months are liable for legal and collection fees, which include 1.5% per month interest (18% A.P.R.)

Is there anyone to whom we may disclose your protected health information, including medical and billing? (Name, relationship, phone #)_____

If you have any special instructions regarding disclosure of your protected health information, please provide them here:

CANCELLATION, NO SHOW POLICY: A physical therapy program is a type of ***contract*** between you, the physical therapist, and the referring physician. Our staff takes pride in its commitment to providing the highest quality of care, and we request that you also **commit to attending your scheduled appointments**. If you must cancel an appointment, please give us 24 hr notice so that we may reschedule your appointment at that time. Additionally, this will allow us to accommodate other patients who require treatment and are waiting for appointments. If more than one appointment is missed without proper notification, we will charge a broken-appointment fee of $35.

_____ **Patient/Guardian Initials**

I have read, understand, and agree to the above information.

Patient Signature **Date**