Alliance Health

Patient Registration Form— *Shaded Areas, Office Only* Date:

Primary Insurance: Medicare ☐ Group Health ☐ Workers Comp ☐ Lien ☐ Other ☐_____			**Secondary Insurance:** Medicare ☐ Group Health ☐ Workers Comp ☐ Lien ☐ Other ☐_____		
☐ New Patient ☐ Re-Start ☐ New Diagnosis ☐ New Insurance				**PTPN** ☐ Yes ☐ No	
Patient #	Title	Patient Name (Last, First, Middle Initial)			
Address		City/State/Zip			
Home Phone ( )	Work Phone ( )		Cell Phone ( )		
Social Security #	DOB	Gender ☐M ☐F	Driver's License #	Insurance Type *PPO, HMO, Medicare, etc*	Email
Referring Physician	Referring NPI (10 digits)	Referring Physician Phone# (		Treating Therapist	
Patient Status ☐ Active ☐ SFA	Primary location CLINIC	Martial Status	Student Y ☐ N ☐	Employment Status	
Occupation	Employer		Employer Phone #		
Address	City/State/Zip				

Are you currently receiving healthcare service through a Home Health Agency (HHA)? ☐ Yes ☐ No

If yes, please provide name and phone number of the HHA._____

Emergency Contact (Name)	Home Phone ( )	Work Phone ( )
Address	City/State/Zip	Relationship to Patient

Financially Responsible Party Other than Patient

Name (First, Middle Initial, Last)			Relationship to Patient
Address			City/State/Zip
Home Phone ( )	Work Phone ( )		Email Address
Social Security #	DOB	Gender ☐M ☐F	Driver's License #

Injury Information

Is condition surgery related? ☐ Yes ☐ No	Date of Surgery	Surgical Procedure	
Is condition accident related? ☐ Yes ☐ No	Was an automobile involved? ☐ Yes ☐ No	Date of Accident	
Describe Accident/Injury/Illness			
Were you injured on the job? ☐ Yes ☐ No	Date of Injury	Are you currently working? ☐ Yes ☐ Full-time ☐ Part-time ☐ No	
Name of employer at time of accident	City, State, Zip Code		
Is litigation (lawsuit) involved? ☐ Yes ☐ No	Name of Attorney	Phone # ( )	

-Office Use Only-	
Diagnosis:	**ICD-9 Code:**
Diagnosis:	**ICD-9 Code:**
Diagnosis:	**ICD-9 Code:**

Insurance Information

Were benefits and authorization verified? ☐Yes ☐No

Primary Insurance In- network ☐ Out-of-network ☐			Pre-Certification ☐Yes ☐No		Visits per Year	
Claims Mailing Address	City, State, Zip Code					
Subscriber Name	Date of Birth	Sex ☐M ☐F	Relationship to Patient			
ID Card # (including alpha prefix)	Group #	Authorization #				
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty $	Visits Remaining	
Deductible Start Amount $	Deductible Remaining Amount $	Pre-Certification Phone # ( )				
Benefits Verified By	Date	Spoke to	Ins. Customer Service Phone # ( )			
Secondary Insurance In- network ☐ Out-of-network ☐						
Claims Mailing Address	City, State, Zip Code					
Subscriber Name	Date of Birth	Sex ☐M ☐F	Relationship to Patient			
ID Card #(including alpha prefix)	Group #	Authorization #				
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay $	Pre-Certification ☐Yes☐No	Visits per Year
Deductible Start Amount $	Deductible Remaining Amount $	Pre-Certification Phone # ( )				
Benefits Verified By	Date	Spoke to	Ins. Customer Service Phone # ( )			

The above description is a quote of your insurance(s) benefits. We assume no liability for any errors made by your insurance carrier(s) in this quotation. It is your responsibility to clarify any discrepancies in eligibility, benefits and/or authorization and inform our clinic immediately. We have reviewed these benefits with you. You understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date	Front Office	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by *Alliance Health* and assigns to *Alliance Health* any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes *Alliance Health* to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or *Alliance Health* for payment of charges to the patient.
4. *Alliance Rehabilitation* reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for *Alliance Health.*

Patient Signature:		Date:
CPM Office Use Only:	*Entered by:*	*Date:*