**Alliance Hand and Physical Therapy Registration Form**

Have you ever been treated for hand or physical therapy before? 🞏 YES 🞏 NO Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever filed any of the following claims? 🞏 Malpractice 🞏 Personal Injury 🞏 NONE

**PATIENT INFORMATION – Please print clearly and complete form fully**

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial \_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_

Sex 🞏 M 🞏 F DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Marital Status: 🞏Single 🞏Married 🞏Divorced 🞏Widowed 🞏Separated

Month Day Year

SSN\_\_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_ Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status 🞏 FT 🞏 PT 🞏 Retired 🞏 Unemployed Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Alliance? 🞏 You are a previous patient 🞏 By a friend / by a previous patient 🞏 MD

🞏 Insurance 🞏 Advertisement 🞏 Internet 🞏 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring MD INFORMATION Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACCIDENT/INJURY INFORMATION**

Injury related to: 🞏 Auto Accident 🞏 Work Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State of Injury \_\_\_\_\_\_\_\_\_\_\_\_

Work related: Was the accident with present employer? 🞏 YES / 🞏 NO - If yes, list employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Auto related: Type of accident: 🞏 Driver 🞏 Passenger 🞏 Pedestrian 🞏 Job 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICARE** Do you have Medicare? 🞏 YES 🞏 NO

***If you have or are receiving home health services and have not been discharged from their care, Medicare will not pay and the patient will be responsible for the balance.*** Are you currently receiving Home Health Services (HSS)?🞏 YES 🞏 NO

If YES, name of agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of HSS you are receiving - \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If NO, have you received HSS in the past 60 days? 🞏 YES 🞏 NO If YES, list agency name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER INFORMATION**  Employment Status 🞏 FT 🞏 PT 🞏 Retired

Employer Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_

**PERSON RESPONSIBLE FOR BILL**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation to patient: 🞏 Parent 🞏 Spouse 🞏 Child 🞏Sibling

(If different from patient)Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_

**PRIMARY INSURANCE** Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: 🞏 Self 🞏 Spouse 🞏 Dependent

(If different from patient) Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_

**SECONDARY INSURANCE** Name of Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder Work Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: 🞏 Self 🞏 Spouse 🞏 Dependent

(If different from patient) Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_ Zip\_\_\_\_\_\_\_

**ATTORNEY INFORMATION** Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Alliance Hand and Physical Therapy, P.C. to render treatment, furnish information and medical records to my physician, insurance carriers, appeal claims denied by my insurance company on my behalf, attorney or employer concerning myself or my dependant’s illness and treatment. I hereby assign to the provider all payment for medical services rendered to myself or my dependants. I understand I am responsible for any amount not covered by insurance. If you are receiving home health services and have not been discharged from their care, Medicare will not pay and the patient will be responsible for the balance.

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2/2015