Centre of Physical Rehabilitation
2301 Coit Road, Suite B
Plano, Texas 750750
Phone: 972-599-9191 Fax: 972-599-2323

PATIENT REGISTRATION AND CONSENT FORM

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: ( )_____

DOB: ____/____/____ Age: ____ Gender: _____ Work: ( )_____

Patient SSN: _____ Cell: ( )_____

E-Mail: _____

Policy Holder: _____ Policy Holder SSN: _____

Policy Holder: DOB: ___/____/____ Policy Holder Address: _____

City: _____ State: _____ Zip Code: _____

Referring Doctor_____ Phone: ( ) _____

Is Injury due to *Motor Vehicle Accident* or *Work Related*? Please circle one.

*****Guarantor information is required and necessary for claims to be processed and paid by the insurance company.**

Policy Holder Employment Information

Employer: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone: ( )_____

Person to contact in case of emergency: _____

Relationship: _____ Phone: ( )_____-_____

I authorize my insurance benefits to be paid directly to the provider. I understand that I am financially responsible for my bill. Insurance or other means of payment provided, does not release me from my obligation toward the entire balance due. I authorize the provider to provide Physical Therapy treatment, to include but not limited to the following: Manual manipulation, mobilization, myofascial release, ultrasound, E-stim, traction, exercise; and to release any information to the insurance company or attorney as necessary to obtain payment for this claim. I have received notification of HIPAA.

Signed: _____ Date: _____