REGISTRATION FORM
FOR NEW PATIENTS

Today's Date:		☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.	
Last Name:	First:	Nickname:	
Birth Date: / /	Sex ☐ Male ☐ Female	Primary Care Physician:	
Address:	City:	State:	Zip:
Email Address:		Social Security No.	

☐ Add my email to your patient contact list. For general communication purposes only, such as updates on our staff, office hours, and new treatment availabilites, **We are fully HIPPA compliant; NO personal medical information will ever be sent via email.** Nickel City does not share or sell our patient information EVER

Cell Phone:	Home Phone:	Work Phone:

Are you a previous patient of ours?

Would you like appointment reminders? ☐ No ☐ Yes, please call ☐ Yes, please text ☐ Yes, please email

PERSONAL INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance Provider:	Primary Carrier Holder's Name:
Your relationship to person:	Primary Carrier Holder's Birth Date: / /
Secondary Insurance Provider:	Carrier Holder's Name:
Tertiary Insurance Provider:	Carrier Holder's Name:

WORKER'S COMPENSATION INFORMATION

Compensation Insurance Carrier:	Case No.	Date of Injury: / /	
Insurance Carrier Address:	City:	State:	Zip:
Caseworker's Name:	Caseworker's Phone:		
Employer Name & Address:	City:	State:	Zip:

Worker's Compensation Board (WCB) Case No.

Referring Compensation Case Physician (if different from Primary):

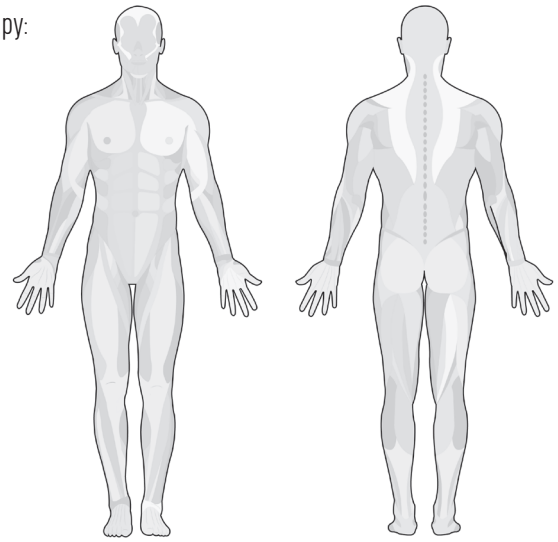
Referring Compensation Case Physician Practice Name:

NO-FAULT INFORMATION

Injured Person Name:		Date of Accident: / /	
No-Fault Insurance Company Name:		No-Fault Claim No.	
No-Fault Insurance Company Address:	City:	State:	Zip:
Contact Person Name:	Contact Person Phone:		

PLEASE ANSWER THE FOLLOWING QUESTIONS IN FULL

Briefly describe your current primary injury, for which you were referred to Physical Therapy:
(use the image to assist with your description)



Any previous history of this condition? If so, explain:

Medical Illness' (i.e. diabetes I or II, high blood pressure, etc.):

Surgeries (if any) and their approximate dates:

Current Medications (you may also provide receptionist with list to copy):

OFFICE PROCEDURES

WORKER'S COMPENSATION/NO-FAULT NOTICE: If you are a Worker's Compensation or No-Fault patient, please list your personal health insurance on the front of this form. We also request that you supply us with a referral if your insurance company requires one. Although we will forward all claims to your Worker's Comp/No-Fault Insurance, we must have this information on file. This is for your protection in the event that your Worker's Comp/No-Fault Insurance fails to make payment on this claim; your personal insurance will work as a backup. If you fail to provide your personal health insurance information and your Worker's Comp/No-Fault denies payment, **you will be responsible for payment.**

LATE SHOW POLICY: Our providers know your time is important and we hope you understand the value of our time as well. We want to be able to provide every patient with all the attention they require. For these reasons, if you arrive more than 15 minutes late for your appointment, it may be necessary to reschedule for a later time or day, unless prior arrangements have been made. **It is at the discretion of the provider to see the patient or ask the patient to reschedule. If it is determined that the provider will see the patient, the patient arriving late may be required to wait until an appropriate opening is available.**

CANCELLATION / NO-SHOW POLICY: Nickel City Physical Therapy P.C. requests 24 hours' notice for canceling an appointment; we ask that you call us as soon as possible to avoid a No-Show fee. Late cancellations may be subject to a $55 fee. **Nickel City Physical Therapy P.C. will charge a $55 No-Show fee for all appointments missed without notification (No-Show).** You will be responsible for this charge and your insurance company will not be billed for that appointment. Chronic no-show/same day cancellations may result in discharge from the practice for noncompliance with the Physical Therapist's plan of care.

AUTHORIZATION FOR PAYMENT & RELEASE OF MEDICAL RECORDS

I certify that the above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Nickel City Physical Therapy P.C. I understand that I am financially responsible for any balance. I also authorize my referring physician insurance company or their representatives, Nickel City Physical Therapy P.C. or insurance company to release any information required to process my claims.

Name (Please Print):

Date: / /

Signature (Self, Parent, or Guardian):