Triangle Physical Therapy

519 Keisler Drive, Suite 204, Cary, NC 27518

Tel: (919) 851-1164 Fax: (919) 851-1196

Patient Registration

First Name_____ M.I._____ Last Name_____

Street Address_____

City_____ State_____ Zip Code_____

Home Phone _____Cell _____ Work _____ Extn._____

Social Security #_____ DOB _____ Gender _____ Marital Status _____

Occupation_____ Email Address _____

Employer Name _____ Employer Address _____

Emergency Contact _____ Relation_____ Ph #_____

Physical Therapy Referring Physician : _____ Ph # _____Fax # _____

Primary Care Physician : _____ Ph # _____Fax # _____

Insurance Information

Primary Insurance Company_____ Phone_____

Policy Holder's Name_____ DOB _____ Relationship to Patient_____

Policy #_____ Group #_____ Effective Date _____

Secondary Insurance Company_____ Phone_____

Policy Holder's Name_____ DOB _____ Relationship to Patient_____

Policy #_____ Group #_____ Effective Date_____

Assignment of Benefits to Triangle Physical Therapy, Inc. and Financial Policy

I hereby authorize to release any medical or other information necessary to process my medical claims and to obtain payment of benefits. I authorize my insurance company, attorney or 3rd party payor to assign all payment benefits directly to Triangle Physical Therapy for the services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I also understand that I will be responsible for any copay or deductible as defined by my insurer. I also understand that my account will become delinquent in 45 days after discharge, and a finance charge of 1.5 % per month will be added to the balance until full payment is received. I will also pay any charges incurred for bounced check ($ 20), collection, court, and attorney fees. A $25 fee will be assessed for a missed appointment unless a **24 hour** notice is given. I certify that above information given is correct to the best of my knowledge.

Patient Signature_____**Date**_____