# PREHAB SPORTS MEDICINE

## Physical Therapy

2871 Post Road, Warwick, RI. 02886 (401) 463-3060

Patient Registration Form (Please Print)

| Last Name | First Name | MI | Nickname |
|---|---|---|---|
| SSN | DOB | | Gender M F |
| Street | City | State | Zip |

| Home Phone | Cell Phone | Work Phone | e-mail |
|---|---|---|---|

Is it OK to leave messages regarding appointments or treatments on an answering machine, voice mail or e-mail? **Yes** ❑ **No** ❑

| Employer | Street | City | State | Zip |
|---|---|---|---|---|

| Name of emergency contact | Phone | Relationship |
|---|---|---|

Diagnosis:

Referring Physician:

Name of parent, guardian or medical power of attorney (POA):

Was this injury the result of an accident? Yes_____ No _____

Motor vehicle _____ Work _____ Other _____

If yes, what was the date of the injury _____

Worker's comp claim number _____

**AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS:**

**Prehab Sports Medicine** is authorized to provide my referring physician, insurance company or their representatives, my attorney and/or _____ all information they may need regarding my condition while under treatment or observation, including, but not limited in history obtained, medical thermograms, physical findings, diagnosis and prognosis.

| | |
|---|---|
| Signature Date | Signature of Parent,Guardian or POA Date |

**FINANCIAL AGREEMENT**

In consideration of the services provided by **Prehab Sports Medicine** at my request and direction, I understand I am responsible for, and agree to pay in full, to the order of **Prehab Sports Medicine**, all charges incurred for services rendered. The payment of co-pays, co-insurance or deductibles are due at time of service. I further understand that in the event that special arrangements have been made to have payment made through an insurance company (i.e., worker's comp or a no-fault claim), and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay any lawful and reasonable interest chargers after thirty (30) days from the date of billing on any unpaid balance.

| | |
|---|---|
| Signature Date | Signature of Parent, Guardian or POA Date |