KAH Premium Physical Therapy

97F Main St.
Stony Brook, NY 11790
P (631) 751-6680
F (631) 675-6264

REGISTRATION FORM

Date: _____ **Referred by**: _____

Patient Name:_____ **E-mail**:_____

Home phone: _____ Cell phone: _____
Work phone: _____
Address:_____ City:_____ State:_____ Zip:_____
Sex: ____ Age:_____ Birth date:____/____/____ Social Security #:_____-_____-_____
Marital Status:_____
Patient employed by:
(company name, address, phone)_____
Occupation: _____

Is this visit going to be covered under the following: Workers' Comp____ No Fault ____
If yes, Insurance Carrier & Address : _____
Adjuster's Name: _____ Phone #: _____
Claim #:_____

Do you have Medical Insurance: YES / NO
If yes, name of Primary Insurance Carrier: _____
Address & Phone # of Insurance Co.: _____
Subscriber ID #: _____ Group #: _____
Policy Holder: Name: _____ Date of Birth: __/____/____
SS#: _____-_____-_____
Employer name, address and occupation:_____
Relation to insured? _____

Do you have Secondary Insurance: YES / NO
If yes, name of Secondary Insurance Carrier: _____
Address & Phone # of Insurance Co.: _____
Policy Holder: Name: _____ Date of Birth: __/____/____
SS# _____-_____-_____
Employer name, address and occupation:_____
Relation to insured?_____

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ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with_____ (Insurance Co.) and assign directly to KAH Premium Physical Therapy all medical benefits, if any, otherwise payable to me for service rendered. I understand that I am fully responsible for all changes whether or not paid by my insurance company. I hereby authorize KAH Premium Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____

Signature of Insured/Guardian Date

MEDICAL AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to KAH Premium Physical Therapy for any services furnished me by that office. I authorize any hold of information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If 'other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or any electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Beneficiary Signature Date