AMWELL ORTHOPAEDIC PHYSICAL THERAPY, LLC

PATIENT REGISTRATION FORM *PLEASE PRINT CLEARLY*

PATIENT NAME first	middle	last	DATE OF BIRTH	AGE
HOME ADDRESS	apt#	CITY	STATE	ZIP CODE
OCCUPATION	SOCIAL SECURITY NUMBER (SSN)	MARITAL STATUS ☐M ☐S ☐D ☐W	SEX	HOME PHONE ( )
E-MAIL ADDRESS				CELL PHONE ( )
EMPLOYER ADDRESS	EMPLOYER'S	WORK PHONE ( )		
DRIVER'S LICENSE NUMBER	IN CASE OF EMERGENCY, CONTACT	PHONE		

SPOUSE OR PARENT'S NAME	SPOUSE OR PARENT'S EMPLOYER	SPOUSE OR PARENT'S WORK PHONE ( )
SPOUSE OR PARENT'S ADDRESS	SPOUSE OR PARENT'S EMPLOYER	SSN & DOB

REFERRING PROVIDER NAME	☐ PRIMARY CARE PHYSICIAN	☐ ORTHOPAEDIC MD	☐ PODIATRIST	☐ OTHER
HOW DID YOU FIND US?	☐ REFERRING PROVIDER	☐ INTERNET	☐ YELLOW PAGES	☐ FRIEND/PATIENT

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for *AmWell Orthopaedic Physical Therapy* to furnish medical treatment to _____ considered necessary and proper in treating his/her physical condition.

Patient Signature / Legal Guardian _____ **Date** _____

PATIENT AUTHORIZATION AND ASSIGNMENT OF INSURANCE BENEFITS

I, _____, hereby authorize and irrevocably assign **AmWell Orthopaedic Physical Therapy** to apply for benefits on my behalf for services rendered by them and request that payments be made by my insurance company and those payments will be sent directly to **AmWell Orthopaedic Physical Therapy**.

I Understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection, I agree to pay reasonable legal fees (30% is deemed reasonable) and expenses incurred as a result of said collection.

I Certify that the information that I have reported with regard to my insurance coverage is correct and I further authorize the release of any necessary information relating to the claim. I understand that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

_____ _____

Signature **Date**