LEVERAGE
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Patient Information

FULL NAME (Last, First, Middle)			SOCIAL SECURITY #	DATE OF BIRTH	SEX: M or F
ADDRESS			CITY STATE	ZIP	
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL		
OCCUPATION			EMPLOYER		

Emergency Contact

NAME	RELATIONSHIP
ADDRESS	PHONE

Insurance Information

PRIMARY INSURANCE	RELATIONSHIP
ADDRESS	PHONE

Responsibility Party (if different than patient; otherwise write same as above)

FULL NAME (Last, First, Middle)		SOCIAL SECURITY #	DATE OF BIRTH	M or F
ADDRESS		CITY STATE	ZIP	
HOME PHONE	CELL PHONE	EMAIL		

PROFESSIONAL SERVICES MUST BE PAID AT THE TIME THEY ARE RENDERED.

Assignment of Benefits: I hereby authorize payment directly to Leverage Physical Therapy of benefits due me for services described above. I understand I am financially responsible for charges not covered by this authorization.
Release of Information: I hereby authorize Leverage Physical Therapy to release any information required to process this claim form.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO PATIENT	DATE