



REGISTRATION FORM SARA JILL MANWILLER, INC

Patient Name (First, Middle, Last) _____

Local Mailing Address (City, State, Zip) _____

Other Mailing Address (City, State, Zip) _____

Phone (Home) _____ (Work) _____ (Cell) _____

Email Address _____

Date of Birth _____ Social Security # _____ Marital Status _____

Employer _____

Employer Address _____

Job Title _____

Diagnosis _____ Date of Injury _____

Who referred you to Jointworx Physical Therapy? _____

Name of nearest relative not living with you _____ Phone # _____

Is this a **Work Comp** injury? Yes or No. _____ If yes, have you reported it to your employer? Yes or No _____

If **Work Comp**, who is the WC insurance carrier? _____ Claim # _____

Auto Accident? Yes or No. Insurance carrier? _____ Claim # _____

Surgery? Yes or No. Type of surgery and date? _____

Insurance Policy Holder (financially responsible person) _____ **Circle here if same as above**

Name _____ Relationship to Patient _____

Address _____

Phone (Home) _____ (Work) _____ Date of Birth _____

Social Security # _____ Employer _____

Insurance Information: Policy # _____ Group # _____

Insurance Company _____ Phone # _____

Co-pay Amount \$ _____ **Deductible Amount** \$ _____ **Is it met for this year?** Y N

Do you have a secondary insurance? Yes or No. If yes, with whom? _____

Because insurance companies vary in their coverage of physical therapy services, we recommend that you call your insurance company to inquire about coverage. **You are responsible for all co-pays, deductibles, and portions of your bill not paid by your insurance company. Co-pays and co-insurance are due at the time of service.** If you pay privately, payments are due at the time of service, unless other arrangements have been made. Initial exams cost between \$125-\$270 and subsequent visits range from \$70-\$200 on the average. Please ask about special arrangements if you do not have insurance or are suffering a financial hardship. **If you are claiming a Workman's Compensation injury, please check with your employer to see that the necessary paperwork has been processed and filed at your place of employment. If your case is denied for any reason, you will be responsible for the bill.**

I certify that I, and/or my dependants, have insurance coverage as stated above, and assign benefits directly to Sara Manwiller Physical Therapy.

Name _____ Date _____

SIGNATURE