RNS PHYSICAL THERAPY

PATIENT REGISTRATION

Name: Date:

Address:

City: State Zip Code:

Cell Phone Number: Home Phone:

Date of Birth: SS#

Sex: Male or Female:

Email:

Today's Visit is a Result: ◯ Work Injury ◯ Auto Accident Date of Accident:
◯ Other:

Health Insurance ◯ Yes ◯ No Pregnant ◯ Yes ◯ No

Employer Information

Name: Phone:

Address:

Supervisor:

Emergency Contact:/Spouse Phone:

TRANSFER OF BENEFITS FROM INSURANCE AND RELEASE OF INFORMATION AUTHORIZATION

I certify that I am or my dependent (s) have/has (n) coverage with _____. I authorize transfer of benefits to RNS Physical Therapy. I understand I am financially responsible for ALL charges incurred whether or not paid by insurance. I authorize use of my signature on all insurance claims.

RNS Physical Therapy may use my health information and may disclose this information to insurance carriers(s) assigned to my claim to determine benefits related to my treatment and as well obtain payments for services rendered.

This authorization will end when current treatment plan is completed or when account is paid in full.

By signing this patient registration you authorize treatment and acknowledge the above statement.

X Date:

Who Referred You to RNS Physical Therapy:

Aurora Location: 645 E. New York Street Aurora, IL 60505 (630)375-1604
Chicago Location: 4341 S. Archer Ave., Chicago, IL (773)579-0520

Where Your Health Improves – Donde Su Salud Mejora

RNS PHYSICAL THERAPY

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)

To carry out Treatment, Payment and Healthcare Operations

By signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. The Practice's "Notice of Privacy Practices" is also provided in the practice waiting room**.** I may also request a copy from this office at any time via US Mail.
4. This Notice of Privacy Practices also describes my rights and the duties of this office **with** respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Printed)

Signature of Individual