Magnolia Physical Therapy Patient Registration

Patient Info

Please check preferred method of communication.

Patient Name: _____ ☐ Home Phone: _____

DOB: _____ Male / Female ☐ Cell Phone: _____

Address: _____ ☐ Email: _____

City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Phone: _____
Relationship: _____

My Condition

Area Injured: _____ Date of Onset: _____

How did your injury occur? Auto Injury? Y / N Work Injury? Y / N other: _____

Surgery? Y / N Date: _____

Prior PT: Y / N When? _____ Where? _____

Payment Info

Insurance

I would like you to deal directly with them. I hereby instruct and direct my insurance company to make payments to Magnolia Physical Therapy Co. on my behalf. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to MPT and I have agreed to pay any balance of said professional service charges over and above this insurance payment.

Policy Info:

Insurance Company: _____ ID# _____ Grp # _____

Insured Name (if other than patient) _____ Insured DOB _____

Worker's Compensation / Auto Injury

Company: _____ Date of Injury: _____ Claim No. _____

Claim Manager Name: _____ Claim Manager Phone: _____

Referral Info

How did you hear about us?

Friend or family Internet Insurance Company Brochure Other

Referring Physician: _____

24-Hour Advance Notice Fee:
If you wish to cancel or reschedule an appointment, we require 24-hour notice. Anything less will result in a $50 fee charged to your account. This policy is out of respect for our therapists and our clients.

HIPAA/Consent to Treat
HIPAA: By signing this form I acknowledge that I have received a copy of the HIPPA "Notice of Information Practices" for Magnolia Physical Therapy Co. and understand it completely.

Consent: By signing this form, I agree and give consent to Magnolia Physical Therapy Co. to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

Patient Signature: _____ Date: _____

If Patient is a minor, Guardian Name: _____ Relationship: _____

Guardian Signature: _____ Date: _____