Registration and Authorization Form

Personal Information:

First Name: ______________________ MI: ______ Last Name: ______________________________

Prefers to be called: ____________ Date of Birth:____________ Male Female

Address: ______________________________ City: ________________ State: ________ Zip Code: ________

E-mail: ____

I acknowledge that some forms of electronic communications are not secure, including some patient education websites that we may use in your care. I can decline creation of any website account at any time by informing my provider. If I email my provider a health-related question, I consent to my provider responding via email. I understand that I am responsible for access and use of the email address provided in writing or verbally and my provider cannot be held liable for inappropriate use of or breach of that email account.

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Where do you prefer to receive calls? Home Work Cell

How do you prefer to receive appointment reminders? Text Message (Standard rates apply) Phone Message) Email

May we notify you of upcoming classes, wellness services and lectures? Yes No

Select the locations where we may leave messages that may contain health information about you:

Home Work Cell None (please do not leave messages containing health information)

Are you under the care of a physician?

For this injury: ______________________________ General physician: ______________________________

Is there anyone involved in your care with whom we may discuss your health information?

Spouse:______________________________ Other: ______________________________

Referring Physician:______________________________ Internist: ______________________________

In the event of an emergency, whom should we contact?

Name:______________________________ Relationship: ______________________________

Daytime Phone:______________________________ Evening Phone: ______________________________

Marital Status: Single Married Divorced Widowed Separated Partnered

Employment Status: Active Duty Full-Time Part-Time Retired Student None

Is this injury related to an auto accident? Yes No If so, in which state did the accident occur? ______________

Is this injury related to another type of accident? Yes No Is an attorney involved? Yes No

Is this a work-related injury? Yes No

	Primary Insurance:	***Secondary Insurance:***
Name of Insured Party:	______________	______________
Date of Birth of Insured:	______________	______________
Relationship to Insured:	______________	______________
Insurance Company:	______________	______________

Registration and Authorization Form

Consent to Treat, Authorization and Release:

I, for myself (or the patient/client named below), hereby consent to such treatment as appropriate for my condition or illness in the judgment of my physical and/or occupational therapist, to be performed or supervised by my physical and/or occupational therapist. I certify that the information given by me for purposes of payment for this treatment is, to the best of my knowledge, complete and accurate.

I acknowledge that I have reviewed the privacy policies and understand that I can request a copy at any time. I authorize the release of any information to third party payers and entities involved in billing and collection in order to process my claims. I hereby assign payment of benefits by my insurance company to my provider, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges becoming patient responsibility.

I understand that members of Hobson Institute professional staff may be employees of the organization or independent associates of the practice and that I should ask to clarify my therapist's relationship with Hobson Institute.

If I schedule a wellness service at Hobson Institute, including massage therapy, personal training, Pilates or group fitness sessions, that I authorize my provider to share my Protected Health Information with the wellness staff member to promote my safe participation in that service.

Signature: ______________________________ *Date:* ______________________________

OFFICE USE ONLY
Referral Source: Physician Patient Returning Patient Insurance Internet Other: ____________________ Date of Injury: ____________________
Primary Therapist: ____________________