



Join the *Movement*

# Registration

## Welcome to Pro•Motion Physical Therapy

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, co-pay, and non-covered service amounts. We do require 24 hours notice of a cancellation, or you may be charged a \$25.00 fee non reimbursable from your insurance company as per Medicare guidelines.

Name \_\_\_\_\_ Date: \_\_\_\_\_  
                    First                    Middle                    Last

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex (circle one) M F Referring Doctor: \_\_\_\_\_

Occupation \_\_\_\_\_ SSN: \_\_\_\_\_ Spouse SSN \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Insurance Information

Please give a copy of your insurance card(s) to the receptionist

#### Primary Insurance

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Group Number \_\_\_\_\_ Policy ID Number \_\_\_\_\_

SSN \_\_\_\_\_ Insured's Relationship to Patient \_\_\_\_\_ Insured's Sex (circle one) M F

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**Insurance Information** *cont'd*

**Secondary Insurance**

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insured's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
First Middle Last

Group Number \_\_\_\_\_ Policy ID Number \_\_\_\_\_

SSN \_\_\_\_\_ Insured's Relationship to Patient \_\_\_\_\_ Insured's Sex (circle one) M F

**In order to comply with the HIPPA Laws we need the following information:**

I wish to be contacted in the following manner: *(check all that apply)*

**Home:**

Ok to leave message with detailed information

Leave message with call back number only

Call cell phone

Written Communication:

OK to mail to my home address

OK to mail to my work address

OK to fax to this number

**Work:**

Ok to leave message

Leave message with call back number

If I am unavailable, you may leave a message with the following people:

\_\_\_\_\_  
 \_\_\_\_\_

**In Case of Emergency Notify** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Are you or your spouse currently employed? Yes No

Are you covered under any employer group health plan or large group health plan? Yes No

\*Is your illness or injury due to any type of motor vehicle or personal injury accident? Yes No

\*Are you covered by Worker's Compensation? Yes No

**\*If you answered yes, please see receptionist for separate forms.**

X \_\_\_\_\_  
*Signature*

**815.521.4400**

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