PATIENT REGISTRATION FORM **HIGH STREET REHABILITATION**

Date:_____

Last Name:	**First Name:**	**MI:**	
Social Security #:	**Date of Birth:**	Sex: M / F	
Marital Status: S____M___D___W___			
Address:	City:	State:	ZIP Code:
Best Phone # to contact you: Home /Cell	**Home:**	**Cell:**	
EMAIL:			
EMERGENCY CONTACT :	Relationship:	Phone #:	
EMPLOYER:	**Employer Address:**	**Employer Phone#:**	
Primary Care Physician:		Phone #:	
Referring Doctor (if different):		Phone #:	
Problem that brought you to this office:			
Are you here to see the **CHIROPRACTOR** or **PHYSICAL THERAPIST** ?			
Was this caused by an **INJURY at HOME ? ____ INJURY at WORK?____SLIP & FALL? ____ CAR ACCIDENT? ____OTHER____**			
How long have you had this condition?			
Did you have surgery for this problem?		Date:	
Additional Information or health concerns:			

INSURANCE INFORMATION

Person Responsible for Account (Policy Holder): **Last Name:**	**First Name:**	**MI:**
Relationship to Patient: SELF SPOUSE PARENT OTHER:_____		
Social Security # of Policy Holder:_____-_____-_____	**Date of Birth:_____/_____/_____**	**Sex: M / F**
Address (if Different):		
EMPLOYER:	Employer Address:	Employer Phone#:
Type of Insurance: MEDICARE / MAJOR MEDICAL / WORKERS COMP / AUTO/NOFAULT		
Insurance Name:	Subscriber ID #	
Group #	Policy #:	
Carrier Address:	Phone #:	
Case# (if applicable):	If WC, Case MGR:	Phone #
SECONDARY INSURANCE Name (if any):	ID #	
Group #	Policy #:	
Carrier Address:	Phone #:	
If you have an **ATTORNEY** Name:	Address: Phone #:	

I authorize High Street Rehabilitation, LLC to **release any medical or other information** acquired during my examination and/or treatment to any insurance company, employer, hospital or any authorized person.

I authorize **payment of medical benefits** High Street Rehabilitation, LLC for all services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance (commercial, worker's comp, auto, etc). In the event of an unpaid balance, I am aware that my bill will be sent to the collection agency and that I will be held responsible for any/and all reasonable charges incurred, including attorney fees.

I agree to **pay my COPAYMENT** of **$_____**at the time of service for each visit. I understand that, by law, NO DISCOUNTS are allowable for this copayment.

Consent to Treat:
I authorize High Street Rehabilitation, LLC to render Physical Therapy / Chiropractic services as determined appropriate to treat my medical condition.

A photocopy of this Assignment of Benefits is considered as effective and valid as the original.

_____	_____	_____
Patient /Responsible Party's Signature	Relationship	Date

PATIENT NAME:_____ DOB:_____