



Thunder Bay Therapy & Sports Medicine

Patient # _____
Diagnosis _____
Therapist _____
Office Use

REGISTRATION INFORMATION

Patient _____ Date of 1st Appt. _____
Last Name First Middle

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Marital Status _____

SS# _____ Sex M _____ F _____ Date of Birth _____

Referring Physician _____ Primary Care Physician _____

Emergency Contact Person _____ Phone _____

Complete Section if Employed

Employer _____ Occupation _____

Address _____

Insurance/Billing

Primary Insurance _____

Secondary Insurance _____

Workman's Comp Claim? No _____ Yes _____ If "yes", Date Injured _____

Auto Accident Claim? No _____ Yes _____ If "yes", Date of Accident _____

Consent for and Conditions of Treatment

I, the undersigned, consent to treatment and have insurance coverage with the above named Primary Insurance Company and assign directly to Thunder Bay Therapy & Sports Medicine, (a.k.a. the Provider) all medical benefits, if any, otherwise assigned to me for services rendered. I understand that I am financially responsible for all charges, co-pays and deductibles whether or not paid by insurance, which is the condition of treatment. The Provider reserves the right to charge interest on account balances of 2% per month, retroactive to the date services rendered, when balances remain unpaid 90 days after discharge from Provider. I hereby authorize the Provider to release all information necessary to secure the payment of benefits from the above party I have disclosed to secure payment. **No condition of treatment may be changed unless in writing by the officers of the Provider.**

Signature of Insured/Guardian

Date

Person Responsible for Payment (if other than patient)

Date