



90 Southside Ave, Suite 225, Asheville, NC 28801  
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www.mountainphysicaltherapy.com

## PATIENT REGISTRATION

*Please use black or blue ink only*

**Patient:** \_\_\_\_\_  
\*Last name                                      \*First Name                                      \*Middle Initial                                      \*Preferred Name

**Mailing Address:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Cell Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Work Phone:** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Primary Contact Number:** Home  Cell  Work

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:** ( ) M ( ) F **Marital Status:** ( ) Single ( ) Married

**Emergency Contact:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

What brings you to Physical Therapy today? \_\_\_\_\_

Date of Current Injury/Onset of pain: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician: \_\_\_\_\_

If not referred by your physician, how did you hear about us? \_\_\_\_\_

Are you a student? \_\_\_\_\_ No \_\_\_\_\_ Yes; School: \_\_\_\_\_

Is this injury the result of an accident involving another party? \_\_ No \_\_ Yes; explain: \_\_\_\_\_

Is this injury work-related? \_\_\_\_\_ No \_\_\_\_\_ Yes; explain: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

*APPOINTMENTS: If you are unable to keep your appointment, please inform our office at least 24 hours in advance so that other patients waiting may be scheduled. There may be a charge for patients that do not call to cancel or reschedule their appointments.*

**MOUNTAIN PHYSICAL THERAPY SERVICES AUTHORIZATIONS**

Please initial beside each appropriate section. \*\*\*Sign at bottom of page

**PATIENT INFORMATION CONSENT:** Initial: \_\_\_\_\_

I have read and fully understand MPTSI’s Notice of Information Practices. I understand that MPTSI may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that MPTSI will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in MPTSI’s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**FINANCIAL AGREEMENT:** Initial: \_\_\_\_\_

Full payment for services rendered is due at the time of service. Our office will accept cash, personal checks, and money orders, Visa or MasterCard. There is a \$30.00 charge for each check returned to us by your bank.

We ask that if you must cancel an appointment to contact us no later than 24 hours before appointment time; otherwise, you may be subject to a cancellation fee.

As a courtesy to our patients, we will file your primary insurance if you supply our office with the proper documents. Please remember that insurance is a contract between you and your insurance company. If any pre-certification is required or if there are limitations to your outpatient physical therapy benefits, including non-covered charges, it is ultimately your responsibility to be aware of these limits and to be financially responsible for any remaining balance. Once insurance has paid in full, any remaining balance will be due within 15 days. If payment arrangements are not made in advance, your account may be turned over to our collection agency with a service charge of 23% included in the balance.

I acknowledge the above financial policy and agree to adhere to the above requirements and know that I, as the patient, am totally responsible for making sure that either my insurance company or myself make full payment to MPTSI. I authorize the use of this signature on all my insurance submissions whether manual or electronic and consent to have insurance payments sent directly to MPTSI.

**CONSENT FOR TREATMENT OF A MINOR:** Initial: \_\_\_\_\_

With my signature below, and, being the parent/guardian of \_\_\_\_\_, I do hereby authorize and request the staff of Mountain Physical Therapy Services Inc to perform any appropriate treatment and/or services for my minor child whether or not I am present at the time treatment is rendered. This consent will be effective from the date it is executed until the date I terminate it in writing.

\_\_\_\_\_  
Name Signature Date  
\_\_\_\_\_  
Parent/Guardian Name Signature Date

I have read the above and understand the terms of this consent form.

\*\*\* \_\_\_\_\_  
Name Signature Date