COLORADO HAND THERAPY, LLC

REGISTRATION FORM

Today's Date:	**Date of Injury:**

PATIENT INFORMATION

Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	P.O. Box:	Birth date: / /	Age:	Sex: ❑ M ❑ F

City:	State:	ZIP Code:	Social Security no.:

Home phone #: ( )	Cell phone #: ( )	Work phone #: ( )	Referring Physician:

E-MAIL ADDRESS (confidential use with web based exercise program):

Employer:	Employer address:	Employer phone no.: ( )

INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this a work/auto injury? ❑ Yes ❑ No **If yes, Claim Number:**

Contact Person: Phone #:

PRIMARY INSURANCE NAME: **EFFECTIVE DATE:**

Claims Address:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **secondary insurance** (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Colorado Hand Therapy. I understand that I am financially responsible for any balance. I also authorize Colorado Hand Therapy or insurance company to release any information required to process my claims.

I have had the opportunity to review Colorado Hand Therapy's Notice of Privacy Practices. The Notice provides detailed information about how Colorado Hand Therapy may use and disclose my confidential information.

I hereby authorize Colorado Hand Therapy LLC – Occupational/Physical Therapists to provide such medical care and to administer such treatment, necessary to me each time I present to the clinic. Such procedures and treatments may include Occupational Therapy or Physical Therapy. To the extent possible, I have been informed of risks and complications that may occur and alternatives that may be available.

Patient/Guardian signature *Date*