



PATIENT REGISTRATION

Patient's Name (last) _____ (first) _____ (initial) _____

DOB ____ / ____ / ____ Age ____ Sex M / F Marital Status S M D W SSN ____ - ____ - ____

Patient's Address _____

City _____ State _____ Zip _____

Phone No (home) _____ (work) _____ (cell) _____

Patient/Responsible Party Employed By _____ Phone No _____

Employer Address _____

Responsible Party _____ Relationship to Patient _____

Responsible Party Address _____

Responsible Party Phone No (home) _____ (work) _____ (cell) _____

Emergency Contact _____ Relationship _____ Phone No _____

Purpose of visit: Illness / Injury / Auto Accident Description _____

Date of Onset/Injury/Accident _____ Date of Surgery _____

Extremity being Treated Left / Right Finger / Thumb / Hand / Wrist / Elbow / Arm / Shoulder

Referring Physician _____ Allergies _____

Primary Insurance Company Name _____

Subscriber's Name _____ SSN ____ - ____ - ____

Subscriber's Employer Name _____ Phone No _____

Subscriber's Employer Address _____

Subscriber's DOB ____ / ____ / ____ Patient's Relationship to Subscriber: Spouse / Child / Self / Other

Secondary Insurance Company Name (if any) _____

Subscriber's Name _____ SSN ____ - ____ - ____

Subscriber's Employer Name _____ Phone No _____

Subscriber's Employer Address _____

Subscriber's DOB ____ / ____ / ____ Patient's Relationship to Subscriber: Spouse / Child / Self / Other

Workers' Compensation Company Name _____

Employer at the time of injury _____ Contact Person _____

Adjuster's Name _____ Phone No _____

Case Manager's Name _____ Phone No _____

Claim No _____ Do you have an attorney? Y / N

Attorney Name _____ Phone No _____

I hereby voluntarily consent to receive treatment for myself or my dependent for my diagnosis according to my treatment plan. I understand that a properly credentialed clinician of Carolina Hand Therapy, Inc. and in accordance with the law will perform my treatment. I further understand that I may rescind my consent at any time and will be informed of the potential consequences of that decision.

I understand and acknowledge that Carolina Hand Therapy, Inc. requires 24 hour cancellation notice for appointments and that a \$25 fee will be charged for missed appointments and appointments not cancelled 24 hours prior to scheduled appointments.

I, the undersigned, authorize the release of any medical information relating to all claims for benefits submitted on behalf of myself or my dependent. I further agree and acknowledge that my signature on this document authorizes Carolina Hand Therapy, Inc. to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself or my dependent. I hereby assign directly to Carolina Hand Therapy, Inc. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred. If my account is turned over for collection, I agree to pay all costs of collection, including a reasonable attorney fee. Photo static copy of this authorization shall be considered as effective and valid as the original.

Patient/Responsible Party _____ Date _____