MOBILIZE PHYSICAL THERAPY PATIENT REGISTRATION

Initial ____________	**ACKNOWLEDGEMENT OF PRIVACY PRACTICES** I have been notified of Mobilize Physical Therapy's Notice of Privacy Practices that describes how my health information is used and shared. I understand that Mobilize Physical Therapy (MPT) has the right to change this notice at any time. I may obtain a current copy by contacting the clinic.
Initial ____________	**TERMS OF PAYMENT/CO-PAYS** A claim will be submitted to your insurance company on your behalf. Your portion of your bill is due upon receipt of statement. If your insurance has a co-pay, it is due at the time of service.
Initial ____________	**MISSED APPOINTMENT POLICY** We require 24 hours notice if you are unable to keep your appointment. A $125 fee may apply after a missed appointment if proper notice is not given.
Initial ____________	**RELEASE OF BENEFITS** I authorize my insurance benefits to be paid directly to Mobilize Physical Therapy. I am responsible for co-payments, deductibles, and non-covered services as determined by my insurance plan at the time of claims processing. I authorize MPT or my insurance company to release any information required for processing of this claim per MPT's Notice of Privacy Practices.
Initial ____________	**RELEASE OF MEDICAL RECORDS** I authorize Mobilize Physical Therapy to release any information to referring or consulting health care providers that may be necessary to administer care. In addition, I authorize my medical records may be released to the following:
Initial ____________	**CONSENT TO TREAT** I consent to receive treatment as prescribed by my doctor or physical therapist.

__________________________________ ________________________

Signature or Parent/Guardian Signature Date

Place an X over your area of symptoms: