12 Booth Drive
Plattsburgh, NY 12901
Phone 518-561-2225 Fax 518- 561-2212

Registration Form (Please Print)

Name____
First Middle Initial Last
Date of Birth______________Age________Sex________SSN__________________
Permanent Address____
City________________________State________Zip Code__________________
Home Phone____________Cell Phone______________Work Phone______________Ext.____
Email Address_______________________________ ☐ Single ☐ Married ☐ Other
Employer______________________________Occupation__________________
Phone_____________________________Address ____________________________
City________________________State________Zip Code__________________
Emergency Contact____
Relationship_________________________ Phone____________________________
Referring Physician______________________Family Physician__________________
Is your condition a result of a work injury? Yes No Initials________
Is your condition the result of an auto accident? ☐ Yes No Initials________

Health Insurance

Primary Health Insurance ______________________________Co-Pay______________
Patient ID Number ___________________________Group Number__________________
Name of Insured ___________________________ Date of Birth of Insured ______________
Secondary Health Insurance ______________________________Co-Pay______________
Patient ID Number ___________________________Group Number__________________
Name of Insured___________________________Date of Birth of Insured ______________

Medicare Waiver of Liability

Medicare will limit (cap) services per year in a private setting only for Physical Therapy, Occupational Therapy, and Speech Language Pathology combined. In the event of a denial, you the patient are responsible to pay for the services.
Initials________

Assignment and Release: I authorize payment of benefits be made directly to this healthcare provider and I understand that I am responsible for charges not covered by this assignment. I also authorize the release of any information requested to process the claim. If I cannot settle my account at the time of visit, I understand special arrangements need to be made. I understand that if my account should become delinquent, I will be responsible for all reasonable collection costs and attorney fees. *I understand that if I cannot attend a scheduled appointment and do not call to cancel that appointment at least 24 hours in advance that I may be charged a no-show fee of $40 and as well as a $10 fee if I do not pay my co pay at the time of my visit.* I also understand that this no-show fee will not be billed to or covered by my insurance and I am responsible.

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Signature of Patient or Patient Representative/Guardian Date