



LMT Rehabilitation Associates, P.C.

REGISTRATION FORM

Please print

Legal Name _____
Last First Middle Initial

Gender: M F Birth Date: _____ Last 4 Digits of Social Security # _____

Street Address Apt# City State Zip Code + 4 digits

Primary Phone# (_____) _____ Circle One: Home Cell Work

Alternate Phone # (_____) _____ Circle One: Home Cell Work

May we leave a message at the above phone number(s) containing your medical information? No Yes

Marital Status (Please Circle One): Single Married Divorced Separated Widowed

Race: (Please Check)

- American Indian or Alaska Native
- Asian
- African American
- More than one race
- Native Hawaiian
- Other Pacific Islander
- White
- Refuse

Ethnicity: (Please Check)

- Hispanic or Latino
- Not Hispanic or Latino
- Refuse

Primary Language Spoken: _____

Employment Status (Please Circle One): Student Full-time Part-time Retired

Name of Employer/Company Phone#

Who referred you for today's appointment? Physician Hospital Friend/Relative Self Website P.T. Other _____

Referring Physician's Name Phone #

EMERGENCY CONTACT INFORMATION

NAME OF EMERGENCY CONTACT PHONE #

_____ Do you want your Medical Health Record or Billing information shared with this person? Yes No
Relationship to Patient

PLEASE FILL IN ALL INSURANCE AND BILLING INFORMATION ON PAGE 2



LMT Rehabilitation Associates, P.C.

Primary Insurance Company Name: _____

Subscriber's Name _____ Birth date: _____

Contract ID# _____ Group # _____

Subscriber's Relationship to Patient: Self Spouse Minor-Child Adult-Child Other _____

Secondary Insurance Company Name: _____

Subscriber's Name _____ Birth date: _____

Contract ID# _____ Group # _____

Subscriber's Relationship to Patient: Self Spouse Minor-Child Adult-Child Other _____

OPEN AUTO/ WORK COMP/ LIABILITY CLAIM BILLING INFORMATION:

Is Auto your Primary Insurance? Yes No

Do you have an Open Claim Letter from your insurance company or adjuster? (required at time of service) Yes No

Do you have an authorization or Open Claim Letter from your Work Comp. or Liability Carrier? (required at time of service) Yes No

**Please complete additional Workman's Compensation or Auto Claim form/questionnaire*

Insurance Co. Name: _____ Circle Type: Auto Work Comp. Liability

Claim# _____ Date of Injury: _____

Claim Adjuster's Name: _____ Phone#: _____

Billing Address: _____
P.O. Box/Address City State Zip Code

Is there an attorney involved in your case? Yes No _____
Attorney Name Phone#

I consent to all treatment as necessary or desirable to the care of the patient named above. This is not restricted or limited to whatever drugs, medicine, laboratory, x-rays, or other studies that may be used by the attending physician or one of his/her nurse or qualified delegates. I am aware of LMT's HIPAA privacy policy and procedures, and understand that a copy will be provided to me at my request. By signing below, I understand that all professional services rendered will be my financial responsibility. I give permission to LMT to bill my insurance company and I will be responsible for any unpaid balances, co-pays, and deductibles. I agree to pay for these services by cash, check, money order, Visa, Master Card, American Express, or Discover Card.

PATIENT / GUARDIAN SIGNATURE

DATE