

Ullucci Sports Medicine & Physical Therapy, Inc.

Patient Registration Form

I have been treated here
in the past

Legal Name _____ DOB _____ Single / Married / Student

Name as it appears on your insurance card: _____

Home Address _____

City _____ State _____ Zip Code _____

Soc. Sec. #: _____ Email Address : _____

Social Security information is REQUIRED FOR ALL UNITED HEALTHCARE & AETNA PATIENTS

Telephone Home _____ Work _____ Cell _____

Diagnosis _____

Referring Physician _____ MD Phone _____

Primary Care Physician _____ Primary Care Phone _____

Were you hospitalized or have surgery for this problem Yes / No; Dates in hospital _____

Injury caused by: Sports Injury / Employment / Auto Accident / Other Accident--Date of Injury: _____

If you were injured at work which state were you injured in? _____ Claim Number: _____

Employer's Name: _____ Employer's Phone #: _____

Case manager's name: _____ Phone number: _____

Insurance and Claim Information

Primary Insurance Information- Please Fill Out

Insurance Subscriber Name (person responsible for account) _____

Subscribers D.O.B: _____ Relationship to Patient: Self / Spouse / Parent

Subscribers Social Security #: _____ Insurance Company _____

Policy Number _____ Group Number _____

Subscriber Employer _____

Employer Address _____

Secondary Insurance Information

Insurance Company _____ Policy Number _____

Attorney Information

Name of attorney : _____ Phone number _____

Attorney Address : _____

Please note patients are expected to know their co-pay/deductible amounts as described in their health insurance Patient Policy Manual. All co-pays/deductibles will be collected on the same day and prior to treatment being rendered.

(Over →)

Consent to Evaluate and Treat

Initials I hereby consent to any diagnostic tests, evaluation, or treatment as deemed necessary by my physician and/or Ullucci Sports Medicine & Physical Therapy, Inc. (hereinafter "USM&PT") and agreed upon in advance by me.

Initials I hereby authorize USM&PT to bill me directly for any co-payments and/or deductibles due as stated in my contract (or contracts) of insurance. I further agree to pay for any and all charges incurred during the course of my treatment at USM&PT that are not covered by my contract (or contracts) of insurance or that exceed the coverage provided under that contract (or under those contracts).

Initials I hereby authorize USM&PT to release all pertinent medical information and/or medical records requested by my insurance company (or companies). I further consent that USM&PT may send a copy of my medical records to my primary and/or referring physician (or physicians).

Initials I hereby authorize USM&PT to bill me \$30.00, above and beyond any charges for services rendered, for each check returned by my bank as unpaid.

Initials I hereby authorize my insurance company (or companies) to pay USM&PT directly pursuant to all contracts of insurance identified herein and otherwise payable to me. In no case shall payments to USM&PT exceed the balance due for charges incurred during the course of my treatment.

Initials I have read and understand the USM&PT HIPAA policy. I further state that I have had the opportunity to ask any questions and receive answers to any questions related to the HIPAA policy.

Initials In the event that my account balance remains unpaid for more than 30 (thirty) days after the date of my final statement (an "overdue balance"), I authorize USM&PT to charge interest at an annual rate of 8% on any unpaid balance until such balance is paid in full. I further consent to pay any and all charges incurred by USM&PT including, but not limited to, a \$100 late payment processing fee, court costs, attorney's fees and/or collection agency fees as a result of my failure to pay any overdue balance on my account.

Signature Verification of Initials

Signature (patient*, parent or legal guardian)

Relationship

Date

*If patient is a minor, a parent or legal guardian must sign.

Where did you hear about us? (Please circle all that apply)

Cable Television

WPRO-Dan Yorke

790 the Score

ESPN / NESN

Varsity Life

Yellow Pages

Golf Channel

Turnto10.com

Our Website
www.risportsmed.com

Discovery Health

High School Athletic Trainer _____

Physician (Dr's Name) _____

Friend: _____