

## Registration for PT Services

**For the client (i.e. the person receiving the service):**

Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Date of Birth:	E-mail Address:	
Work Phone:	Employer:	Occupation:	
Emergency Contact Phone:	Emergency Contact Name:	Emergency Contact Relationship to Client:	

**For the subscriber (i.e. the insured party) if the client is not also the subscriber:**

Last Name:	First Name:	Middle Initial:	Relationship to Client:
Address:	City:	State:	Zip Code:
Home Phone:	Date of Birth:	E-mail Address:	

**For the subscriber (i.e. the insured party) if you did not provide a copy of your insurance card to ZPT:**

Insurance Company:	Policy Number:	Group Number:	Insurance Company Phone#:
Insurance Company Address:	City:	State:	Zip Code:
Claim Number (if applicable):	Case Manager (if applicable):	Case Manager Phone #:	Injury Date (MVA or work injury)

**Clients and subscribers are responsible for knowing the answers to these questions!**

- Do I need pre-authorization/authorization for PT services from my insurance company? How do I obtain it?
- Does my insurance company require a doctor's prescription for physical therapy services? Prior to service? (e.g. EBMS)
- Do I have a deductible? What is it?
- How close am I to meeting my deductible?
- Do I owe a co-payment on PT services? What is it?
- Am I close to my max yearly and/or lifetime benefit?
- Is the PT I will be working with a participating provider in the eyes of my insurance company?
- If the PT is not a participating provider, what are the consequences?

**Please read the following carefully:**

I verify that the above information is correct. I authorize Zombro Physical Therapy (ZPT) to file for insurance benefits on my behalf, and to share information regarding my case with my insurance company, physician(s), and attorney (if applicable). This signed statement will be placed in my file for signature authorization to my insurance company. Benefits payable will be assigned to ZPT. I understand that I am ultimately responsible for the payment of all charges regardless of my insurance coverage and I accept responsibility for any charges incurred. If I am not covered by an insurance company approved by ZPT for this service, I agree to pay 100% of my charges at the time of service. I consent to physical therapy evaluation and treatment. I read and understood the ZPT Privacy Policy.

**Client Signature:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ZPT Initials: \_\_\_\_\_

**Guardian Signature:** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ZPT Initials: \_\_\_\_\_