DANIEL ARYEH, P.T. LLC

PATIENT REGISTRATION FORM

Appointment Date : _____ / _____ /_____ Time: ______________

DOB : _____ / _____ / _____ Age : _____ Sex: ______ SS# : __________________________

Marital Status : q Single q Married q Widowed q Divorced

Last Name : ______________________________ First Name : _______________________ MI: _________

Address : ____ Apt # : _____ Email: _________________________

City : ___________________________________ State : ___________________ Zip Code : ___________________

Home Tel # : _________________ Business Tel # : ____________________ Cellular Tel # : _____________________

Occupation : ___________________________________ Employer : ____

Referring Physician : _____________________________________ Telephone # : ______________________________

Referring Physician Address : ____

Primary Care Physician: ____

Reason for Visit : ____

Insurance Information:

Primary Insurance: ____ I.D. # : ________________________

Insured Name (if not the patient) : __________________________ DOB : ____/____/____ SS# : __________________

Telephone # : _____________________________________ Relationship to the Insured : q Spouse q Child q Other

Secondary Insurance: ____ I.D. # : ________________________

Insured Name (if not the patient) : __________________________ DOB : ____/____/____ SS# : __________________

Telephone # : _____________________________________ Relationship to the Insured : q Spouse q Child q Other

Name of Beneficiary : __________________________ Health Insurance Claim Number (HICN) __________

I request the payment of authorized Medicare/Other Insurance company benefits to be made either to me or on my behalf directly to Daniel Aryeh, P.T., LLC for services furnished to me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or any other insurance company any information needed for this or a related Medicare/ Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed my signature authorizes releasing of the information to the insurer or agency shown. In Medicare/Other Insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare/Other Insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and the non covered services. Coinsurance, and the deducible are based upon the charge determination of the Medicare/Other Insurance company. If my account is placed in collection, I understand that I will be responsible for all collection fees.

Signature of the Insured Payer : ____ Date : _________________