C.O.A.S.T. PHYSICAL THERAPY SERVICES
Patient Registration Form

Patients Name _____ **Todays Date** _____

Parents Name (if minor) _____ **Parents Phone** _____

Address _____ **Home Phone** _____

City _____ **State** _____ **Zip Code** _____ **Mobile Phone** _____

Date of Birth _____ **M/F** _____ **Marial Status-S/M/D/W** _____

Employer _____ **Spouse/Partner Name** _____

Employer Address _____ **Employer Phone** _____

Date of Injury/Date of Surgery _____

Referred by _____ **Address** _____

Phone _____

***PRIMARY INSURANCE** _____

Name of Primary Insured _____ **DOB** _____

ID# _____ **Social Security** _____

***SECONDARY INSURANCE** _____

Name of Primary Insured _____ **DOB** _____

ID# _____ **Social Security** _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I hereby instruct my insurance company/companies or attorney to pay directly to COAST Physical Therapy Services any benefits allowable for their professional services rendered tome at their facility. Any sum of money paid under the assignment shall be credited to my account. I also assume all responsibility for any balance on my account and agree to pay any additional charges equal to the cost of collection including agency, attorney fees and court costs incurred and permitted by laws governing these transactions. Interest on unpaid balance will be charged at 18% per month on accounts past 60 days. I also authorize COAST Physical Therapy Services to provide any and all information that insurance may require to facilitate this process.

Date: _____ **Patient/Parent Signature** _____