Body Elite Physical Therapy, Inc.

3052 Valley Avenue, Suite 101
Winchester, VA 22601

Registration Form

(please print)

Patient Information

SSN:__________________Primary Care Physician_______________________Referring Physician____________________

Patient's Last Name:__________________________________First________________________Middle Initial__________

Address:____City________________________State______Zip_________

Telephone Home:_________________Work:___________________Cell:___________________Date of Birth:____________

Email:____ I prefer to be contacted by___________________________

Marital Status (please circle) Single Married Divorced Separated Widowed

Chose clinic because (please check one) Dr. Insurance Plan Internet Family Friend Close to home/work Yellow Pages Other _________________________

Insurance Information

Please Indicate Primary Insurance and ID #____

Policy Holder's Last Name:____________________________First_______________________Middle Initial_____

Address (if different):_____________________________City______________________State_______Zip________

SSN:__________________Date of Birth______________________ Employer:______________________________

Patient's Relationship to Policy Holder: Self Spouse Child Other

Please Indicate Secondary Insurance and ID #____

Secondary Policy Holder's Name, DOB, SSN:____

In Case of Emergency

Contact:____________________________Relationship to Patient_________________Phone__________________

The above information is true to the best of my knowledge. I authorize Body Elite Physical Therapy, Inc. to provide treatment to myself and / or above named patient. I also authorize the release of any information required to process my claims to my insurance carrier(s) by Body Elite Physical Therapy, Inc. I also authorize my insurance benefits be paid directly to Body Elite Physical Therapy, Inc. I understand that I am financially responsible for any balance after insurance has made payment.

Patient / Guardian Signature **Date**

____ _____________________________

Office Use Only

Name of caller________________________ Effective Date_________________________

Coverage__________________________ Copay or Co-Insurance_________________________________

Deductible Amount_____________How much has been met this year____________ When does it start_____________________

Maximum Dollar Amount___________________________________How much has been met this year____________________

Limit of Visits_________________________________Limited # of modalities per visit__________Used this year___________

Pre-authorization number _____________________________Number of visits__________Expiration date__________________

PCP Referral number_________________________________Number of visits__________Expiration date__________________