MINNESOTA THERAPY & BALANCE CENTER LLC

REGISTRATION FORM

Today's Date:____/____/_____ Estimated onset date of symptoms of which you are receiving therapy:____/____/_____

PATIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____

Date of Birth:___/_____/_____ Age:____ Sex: M F

Marital Status:_____ Occupation:_____ Employer:_____

Home/Mailing Address:_____

City:_____State:_____ Zip Code:_____ Email: _____

Home:_____-_____-_____ Cell/Other:_____-_____-_____ Referring Physician:_____
(Please circle preferred method of phone contact)

Is the condition for which you are referred to therapy related to an auto accident or worker's compensation? YES NO

Have you received outpatient physical, occupational, or speech therapy in 2024? YES NO

Are you currently receiving home healthcare? YES NO

INSURANCE INFORMATION

Please give your insurance card(s) to the receptionist

Primary Insurance:_____ Patient's Relationship to Subscriber:_____

Subscriber's Name:_____Subscriber's Date of Birth:___/___/_____
(if different from Patient) (if different from Patient)

Secondary Insurance:_____ Patient's Relationship to Subscriber:_____

Subscriber's Name:_____ Subscriber's Date of Birth:___/___/_____
(if different from Patient) (if different from Patient)

IN CASE OF EMERGENCY

Name of local relative or friend:_____Relationship:_____Phone #:_____-_____-_____
(living at different address)

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the facility. I understand that I am financially responsible for any balance. I also authorize Minnesota Therapy & Balance Center LLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature: _____ Date:_____/_____/_____