PHYSICAL THERAPY SOLUTIONS, PLLC
ALAN J. PIETRUSZKIEWICZ, MSPT
8201 Atlee Road, Suite D, Mechanicsville, VA 23116
Tax ID 20-4067664 Phone 804-569-1787 FAX 804-569-9787

PATIENT REGISTRATION
MEDICAL RELEASE
BENEFITS ASSIGNMENT

Please Print the Following Information

				Patient Account Number	Date of First Visit	
Patient's Name (First, Middle Initial, Last)				Social Security Number	Home Phone Number	
Street Address				City	State	Zip Code
Date of Birth	Age	Sex	Marital Status	Occupation	Work Phone Number	
Employer's Name and Street Address				City	State	Zip Code
Name of Spouse or Next of Kin (First, Middle Initial, Last)			Relationship	Spouse Employer Name	Spouse Work Phone Number	
Spouse Employer Street Address				City	State	Zip Code
Responsible Party's Name (First, Middle Initial, Last)				Relationship	Home Phone Number	
Responsible Party's Street Address				City	State	Zip Code
Is Illness or Injury Work-Related?	If Yes, What is the Name of the Person at Your Employer Who Should Receive Workers' Comp Info					Date of Injury
If an Accident, We Must Have the Following:			Date and Time of Accident	Date and Time You First Saw a Physician		
If This Your First Visit to Physical Therapy Solutions, PLLC, Who Referred You Here?						

INSURANCE INFORMATION

Primary Insurance Company Name	Policy Number	Group Number	
Primary Insurance Company Address	City	State	Zip Code
Subscriber Name	Relationship		
Secondary Insurance Company Name	Policy Number	Group Number	
Secondary Insurance Company Address	City	State	Zip Code
Subscriber Name	Relationship		

PAYMENT INFORMATION

Your insurance company will be billed for covered services, and any unpaid balance will be the responsibility of the patient or responsible party. Parents or guardians are responsible for payment with regard to a minor. The balance of the account will be due and payable if the insurance company has not paid within 45 days or if Workers' Compensation has not paid within 60 days.

AUTHORIZATION TO RELEASE INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

I authorize payment directly to Physical Therapy Solutions PLLC of benefits otherwise payable to me. Also, by my signature and copies thereof, I hereby authorize Physical Therapy Solutions to provide physical therapy to me/my minor child and to release information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company regarding my claim. I understand that I am financially responsible for all the charges arising for the treatment of the above named patient. If my account is turned over to an attorney for collection, I will be responsible for all attorney fees, which are usually 33% of the unpaid balance, and all court costs incurred.

I also understand that I am responsible for any fees incurred for transferring my medical records.

I HAVE READ AND UNDERSTAND THE ABOVE. SIGNATURE ___________________________ DATE __________