



PATIENT REGISTRATION FORM

3242 20th St. S. • Fargo, ND 58104
Phone: (701) 893-BODY (2639)
Fax: (701) 893-2638
www.bodyworksfargo.com

Patient Name: (print) _____ Date of Birth: _____ Age: _____
First Name, MI, Last Name

Responsible Party: (if minor) _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: () _____ Home Phone: () _____

Social Security Number: _____ E-mail Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: () _____ Alternate Phone: () _____

Reason for Visit: _____ Referred By: _____

Have you had physical therapy treatment within the last calendar year? YES NO if so, how many visits? _____

PATIENT EMPLOYMENT INFORMATION

Employed: Full-time Part-time Retired Unemployed Disabled Student: Full-time Part-time

Employer: _____ Occupation: _____

Address: _____ Business Phone: () _____

City: _____ State: _____ Zip: _____

PATIENT BILLING & PAYMENT INFORMATION

Method of Payment (check all that apply, we will scan your current insurance card(s) into our computer system):

[] Cash [] Private Health Insurance [] Medicare [] Secondary Insurance [] Medicaid [] TriCare/Champus

PLEASE SPECIFY CARD HOLDER'S NAME: _____ Date of Birth: _____

[] Workforce Safety Insurance Claim Number: _____

[] Other..... Specify: _____

PATIENT FINANCIAL POLICY FOR BODYWORKS PHYSICAL THERAPY

- I have presented a valid insurance card to Bodyworks Physical Therapy. If my insurance changes or is updated, I will notify Bodyworks Physical Therapy as needed.
We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due at the time you check in for your appointment.
Medicare: Our office is a Medicare participating provider and we will bill Medicare for you.
Medicaid: Our office is a NDMA and MNMA participating provider and we will bill Medicaid for you.
Worker's Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit to bill the worker's compensation insurance company.
Auto Insurance: If your visit is due to injuries sustained in a car accident and you plan on submitting it to your auto insurance, we will need your policy, claim number and address to submit your claim to.
I hereby assign all insurance benefits (or services rendered to which I am entitled) to Bodyworks Physical Therapy.
Methods of Payment: Our office accepts cash, personal check, Visa, Mastercard & Discover Credit Cards and patient financing options may be available in some cases.
Returned Checks: We assess a \$25.00 NSF charge and report to the local district attorney's office, checks that are not paid within 2 weeks of being returned to our office.
If not paid according to terms, I understand that Bodyworks Physical Therapy reports to an outside collection agency.
Cancellations/No-show for your appointment: If you are unable to keep a scheduled appointment, we require a 24-hour notice or you may be charged a \$25.00 fee.
The patient (guardian) is ultimately responsible for all fees for services. I have read, understood and agreed to the above financial policy for payments of professional fees.

Patient/guardian signature Date: _____