Advanced Care
PHYSICAL THERAPY, AQUATIC & FITNESS CENTER
Personal care that gets you results.

REGISTRATION FORM

924 Main Street, Niagara Falls, NY 14301 Phone (716) 282-2888 • Fax (716) 285-1281

TODAY'S DATE:	FAMILY DOCTOR:	SPECIALIST:
PATIENT'S NAME: _____	ADDRESS: _____ CITY:_____ STATE:_____ ZIP CODE:_____	
BIRTH DATE: PHONE NUMBER: ( ) CELL NUMBER: ( ) EMAIL:	SSN#: EMERGENCY CONTACT: NAME: PHONE NUMBER: ( )	SEX: ❑ M ❑ F
OCCUPATION:	EMPLOYER: PHONE NUMBER: ( )	
MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED	SPOUSE'S NAME: DOB: SSN#	
REFERRED TO CLINIC BY: (PLEASE FILL IN ONE OF THE FOLLOWING)	DR:	FAMILY:
OTHER:	FRIEND:	ADVERTISEMENT:
IF PATIENT IS A MINOR FATHER'S NAME	DOB: SSN#	PHONE: ( )
MOTHER'S NAME:	DOB: SSN#	PHONE: ( )

RELEASE OF INFORMATION

I GIVE PERMISSION TO ADVANCED CARE PHYSICAL THERAPY, AQUATIC & FITNESS CENTER TO RELEASE INFORMATION TO MY INSURANCE COMPANY ATTORNEY, ASSIGNEES AND/OR BENEFICIARIES.

ASSIGNMENT OF BENEFITS

I AUTHORIZE PAYMENT DIRECTLY TO ADVANCED CARE PHYSICAL THERAPY, AQUATIC & FITNESS CENTER FOR SERVICES RENDERED.

_____ _____
SIGNATURE DATE

CONSENT TO PHYSICAL THERAPY CARE

KNOWING THAT I AM IN NEED OF PHYSICAL THERAPY CARE, I VOLUNTARILY CONSENT TO PHYSICAL THERAPY SERVICES. I UNDERSTAND THAT THIS WILL INCLUDE ANY EVALUATIVE PROCEDURES AND MEDICAL TREATMENT MY THERAPIST OR HIS/HER DESIGNEES MAY PRESCRIBE. I UNDERSTAND THAT I HAVE THE RIGHT TO ASK MY THERAPIST TO EXPLAIN ANY PROCEDURE AND TREATMENT PRESCRIBED SO THAT I FULLY UNDERSTAND THE TREATMENT RECOMMENDED. I FURTHER UNDERSTAND THAT I HAVE THE RIGHT TO CONSENT OR TO REFUSE ANY PROCEDURE MY THERAPIST MAY RECOMMEND.

_____ _____
SIGNATURE DATE