

# Registration Information Consent/Responsibility

(Scroll down to page 2 for sample form.)



Name of Patient: \_\_\_\_\_

How did you hear about our facility?  Doctor  Friend  Family  Co-Worker  Internet  Other

**Upon your initial appointment** you must provide our office with your current insurance information. We will bill your insurance as a courtesy. Under your health plan, you are financially responsible for co-payments, co-insurance, or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance, regardless of third-party policies, Workers' Compensation, or private health insurance. A "letter of protection" may be accepted and will be honored for two years from first date of service.

**We ask that you contact your insurance carrier to verify your coverage for Outpatient Physical Therapy Services.** This will provide you with a guideline of physical therapy benefits payable to Doeberling-Muccio Physical Therapy, Inc.

**Beginning November 10, 2010, there will be a \$20.00 charge billed directly to the patient for a no-show appointment. This charge will also apply to repetitive cancellations, as determined by D-MPT management.**

By signing this document, you accept full responsibility for payment of all charges and/or reimbursement.  
Thank you for choosing Doeberling-Muccio Physical Therapy!

Name of Patient/Legal Guardian or Parent: \_\_\_\_\_

Signature of Patient/Legal Guardian or Parent: \_\_\_\_\_ Date: \_\_\_\_\_

**We accept VISA or MasterCard for any outstanding balance, Co-pay, Co-Insurance due. Complete the information below for credit payment.**

*I authorize processing by credit/debit for any outstanding balance, Co-pay, Co-Insurance due of the patient listed at the top of this form.*

Name as it appears on card: \_\_\_\_\_

VISA  MasterCard Card Type:  Credit  Debit

Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ 3-Digit Code (on back): \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature on file: \_\_\_\_\_ Date: \_\_\_\_\_

 **Note: If you don't have a digital signature, you must sign the form in person before any treatment.**  
*To learn more about digital signature, [click here.](#)*

Select location to submit form	
Austintown	Kinsman
Niles	Warren

Interactive 11/09

# SAMPLE FORM

## Registration Information Consent/Responsibility



**Doeberling-Muccio**  
Physical Therapy, Inc.  
*See what we can do to improve the quality of your life.*

Name of Patient: Joe Doe

How did you hear about our facility?  Doctor  Friend  Family  Co-Worker  Internet  Other

**Upon your initial appointment** you must provide our office with your current insurance information. We will bill your insurance as a courtesy. Under your health plan, you are financially responsible for co-payments, co-insurance, or deductibles for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance, regardless of third-party policies, Workers' Compensation, or private health insurance. A "letter of protection" may be accepted and will be honored for two years from first date of service.

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By signing this document, you accept full responsibility for payment of all charges and/or reimbursement.  
Thank you for choosing Doeberling-Muccio Physical Therapy!

Name of Patient/Legal Guardian or Parent: Joe Doe

Signature of Patient/Legal Guardian or Parent: \_\_\_\_\_ Date: 11-05-09

**We accept VISA or MasterCard for any outstanding balance, Co-pay, Co-Insurance due. Complete the information below for credit payment.**

*I authorize processing by credit/debit for any outstanding balance, Co-pay, Co-Insurance due. of the patient listed at the top of this form.*

Name as it appears on card: Joe Doe

VISA  MasterCard Card Type:  Credit  Debit

Card Number: 1234-5678-9999-0000 Expiration Date: 11-02-12 3-Digit Code (on back): 369

Billing Address: 68 Sugarland Drive

City: Poland State: OH Zip: 44514

Signature on file: \_\_\_\_\_ Date: 11-05-09

 **Note: If you don't have a digital signature, you must sign the form in person before any treatment.**  
*To learn more about digital signature, [click here](#).*

Select location to submit form

**Austintown**

**Kinsman**

**Niles**

**Warren**