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 Phone 631-659-3800  
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 www.glickpt.com

**PATIENT REGISTRATION**

PATIENT INFORMATION			PRIMARY INSURANCE	
Patient Name			Insurance Company	
Address			Subscriber ID #	
City	State	Zip Code	Group #	
Date of Birth			Phone	
Home Phone				
Office Phone			SECONDARY INSURANCE	
Cell Phone			Insurance Company	
Email Address			Subscriber ID #	
Gender			Group #	
Primary Physician			Phone	
Referring Physician				
Body Part / Surgery			WORKER'S COMP / NO FAULT	
Date & Time of Evaluation			Insurance Company	
			Contact Person	
			Claim #	
EMERGENCY CONTACT			Policy #	
Name			Date of Injury / Accident	
Relationship			Other	
Phone				

**CONSENT TO TREATMENT:** I consent to rehabilitation and related services at Glick Physical Therapy, PC. In doing so, I understand that such rehabilitation and related services may involve bodily contact or palpation.

**TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive my claim I may have from failure to do so.

**LIABILITY:** I know and agree that Glick Physical Therapy, PC is not responsible for loss or damage to personal valuables.

**WAIVER AND RELEASE:** I hereby release, discharge and acquit Glick Physical Therapy, PC, it's agents, representatives, affiliates, employees or assigns, of and from any and all liability, claim, demand, damage case of, action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow, emergency or medical services, including but not limited to ambulance service, EMT, physician or urgent care services.

**AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to Glick Physical Therapy, PC and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or requested in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

**NOTICE OF PRIVACY:** I have read the Notice of Privacy Practices and fully understand its contents.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_