NEW DIMENSIONS PHYSICAL THERAPY
PATIENT REGISTRATION FORM
Kern-Steiner, Inc.

NAME:_____ DOB: _____
LAST FIRST M.I. MM/DD/YYYY

ADDRESS: _____
STREET

_____ _____ _____
CITY STATE ZIP CODE

HOME PHONE: _____ WORK: _____

CELL PHONE: _____ FAX: _____

E-MAIL ADDRESS: _____
(Do we have permission to add you to our mailing list? Yes_____No_____)

In case of emergency, whom should we contact?_____
Relationship:_____Telephone #:_____

CURRENT HEALTH COMPLAINTS: _____
_____DATE OF INJURY: _____

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT? _____

Please select who you were **SPECIFICALLY** referred to:

New Dimensions Physical Therapy____ Rebecca____ Debbie____

How did you hear about us? Please check all that apply.

Website Doctor: _____ Friend/Family: _____

Other (please specify): _____

INSURANCE WAIVER: New Dimensions Physical Therapy (NDPT) is a FEE-FOR-SERVICE CLINIC. **PAYMENT IS DUE AT THE TIME OF YOUR VISIT.** NDPT is not an insurance provider, nor do we bill insurance on your behalf. However, we do provide our patients with an invoice that has all of the information necessary to self-file for insurance reimbursement as an OUT OF NETWORK PROVIDER. We will assist you in any way we can to help you get the fully allowable reimbursement.

New Dimensions Physical Therapy is NOT a Medicare provider. If you receive physical therapy from our clinic, MEDICARE WILL NOT REIMBURSE YOU. There are other physical therapy clinics that do accept Medicare benefits, and we will be happy to provide you with a referral to those clinics.

Your signature below indicates that you fully understand the cost of our services and that New Dimensions Physical Therapy is a FEE FOR SERVICE CLINIC, DOES NOT FILE INSURANCE, IS OUT OF NETWORK, AND IS NOT A MEDICARE PROVIDER.

_____ _____
Signature **Date**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I, the patient named above, authorize New Dimensions Physical Therapy to furnish insurance companies and/or physicians with medical information they may request regarding my condition or treatment.

_____ _____
Signature **Date**