Orthopedic Physical Therapy Specialists, Inc.

Dr. Karl J. Sheaffer PT DPT
Lehigh Valley Office Plaza
1150 Glenlivet Dr. Suite A-14
Allentown, PA 18106
Phone 610-336-4300
Fax 610-336-0971

REGISTRATION FORM

(Please Print)

Today's Date _____/_____/_____ PCP_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Drivers License and State	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address / P.O. Box	Social Security	Home Phone No. ( )

Email	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital
❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other _____

Other Family Members Seen Here _____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No.
Relationship to Patient			( )

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ HIGHMARK BC ❑ AETNA ❑ CAPITAL BC ❑ MEDICARE ❑ KHPC

❑ KHP EAST ❑ AMERIHEALTH ❑ WC ❑ AUTO ❑ CIGNA ❑ Other _____

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Name of Secondary Insurance (if applicable) Subscriber's Name	Group #	Policy #

IN CASE OF EMERGENCY

Name of Local Friend or Relative	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

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Insurance Authorization and Acceptance of Financial Responsibility

I authorize the release to my insurance company(s) any information necessary to process my insurance claim. I understand that in executing this authorization I waive the right for such information to be privileged. I also authorize payment of medical benefits to be made directly to Orthopedic Physical therapy Specialists, Inc., Lehigh Valley Office Plaza, 1150 Glenlivet Dr., Suite A14, Allentown, PA 18106. A photocopy of this authorization shall be considered as valid as the original.

I agree to accept financial responsibility for any services provided by OPTS, INC.
_____initial

Non Participating Provider and Valid Insurance Referral

I accept responsibility for all outstanding balances for services, rendered by Orthopedic Physical Therapy Specialists, Inc., that may occur if my health insurance company determines that Orthopedic Physical Therapy Specialists, Inc. is not considered a participating provider in my health insurance's network.

I also accept responsibility for any outstanding balances that may occur if my insurance requires a referral and I do not have a valid referral for the services provided by Orthopedic Physical Therapy Specialists, Inc. **_____initial**

Payment Policy

All copays are expected at time of service and monthly invoices are due within 30 days of billing date. In the event an invoice becomes 30 days or more past due, it will be placed with Hamilton Law Group for collection. I/we agree to pay a service charge of 1.5% per month (18% APR), and any and all collection and reasonable attorney fees. **_____initial**

By accepting responsibility, I realize that I will be billed for any balances on my account left unpaid by my insurance company.

Signature:
_____

Print Name:
_____

Date:
_____

Witness:
_____