LA PINE
PO Box 1888, La Pine, OR 97739
(541)536-6122 – FAX (541)536-6123

LA PINE/SUNRIVER Physical Therapy
Legendary Care

SUNRIVER
PO Box 4185, Sunriver, OR 97707
(541)593-8535 – FAX (541)593-0316

****Please Review and update the information Below to the best of your ability****

Patient Registration

CURRENT PATIENT INFORMATION –PLEASE PRINT

Last Name:
First Name:
Middle Name:
Address:
City:
Zip:
Home Phone:
Work Phone:
Mobile Phone:
Sex: **M** or **F**
Date of Birth:
Social Security No.:
Patient email:

Guarantor information (to whom statements are sent)

Name:
Address:

Relationship to patient: _____
Date of Birth:
Social Security No.:
Phone:

Emergency Contact Information

Name:
Relationship:
Phone:
Mobile Phone:

Primary Insurance Information

Insurance Plan Name:

Policy Holder (if other than Patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employers Name

Policy Information

Patients Relationship to Policy Holder:
ID/Certification No.
Policy/ Group No.

Secondary Insurance Information

Policy Holder (if other than Patient)

Last Name:
First Name:
Middle Name:
Address:
City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**
Employers Name

Policy Information

Patients Relationship to Policy Holder:
ID/Certification No.
Policy/ Group No.

ASSIGNMENT AND RELEASE:

- I hereby assign my insurance benefits to be paid directly to the physician.
- I understand that I am financially responsible for all non-covered services, copays, deductibles and/or coinsurance. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize the physicians to release any medical information required to process this claim.
- I authorize my provider's office to contact me by telephone to remind me of appointments.
- A fee for no shows may apply.

Signed: _____Date: _____