

# REGISTRATION FORM- J.T.S.

MARION

Last Name: \_\_\_\_\_ Initial: \_\_\_\_\_ First Name: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Previous Address: \_\_\_\_\_

E-mail address: \_\_\_\_\_ May we send you our Newsletter: YES NO

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell# \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security: \_\_\_\_\_ Sex: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Next M.D. Appt: \_\_\_\_\_

Responsible For Medical Expenses	
Parent _____ Spouse _____ Self _____	Work Accident _____ Auto Accident _____
Name: _____	Attorney: _____
Address: _____	Address: _____
SS#: _____	Atty Phone: _____
Date of Birth: _____	Police Report Copy: Yes No
Employer: _____	Auto Ins Co: _____
Employer Phone: _____	Ins Phone: _____

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Primary Ins: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Phone# \_\_\_\_\_

Secondary Ins: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Subscriber: \_\_\_\_\_ Phone# \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Brief Description of Incident: \_\_\_\_\_

Have you had an: MRI CT-scan X'ray Other \_\_\_\_\_

Brief History/Medications: \_\_\_\_\_

Pregnant? Yes No High Blood Pressure? Yes No Cancer? Yes No

How did you hear about us? M.D. Advertisement Friend Internet Other

## Insurance Authorization and Assignment

I hereby authorize treatment of the patient named above and agree to pay all fees and charges for services rendered. I authorize Joyner Therapy Services to submit billing and furnish information to insurance carriers concerning the illness and treatment of the patient named above. I hereby assign all payments from insurance carriers to be paid directly to Joyner Therapy Services for all medical services rendered.

## Notice of Privacy Practices

I acknowledge that I have reviewed a copy of the Notice of Privacy Practices of J.T.S..

\_\_\_\_\_  
Name (Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature Relationship