



Pro Motion Rehab, Inc.
 1787 W. US Hwy 64 Suite #3
 Murphy, N.C. 28906
 Office: 828-837-0400
 Fax: 828-837-0404

Patient Express Registration

Today's Date : _____

Please fill out entire form Completely & Legibly

1. Personal Info

_____ Male Female

Last Name _____ First Name _____ Age _____

Street Address _____ City _____ State _____ ZIP _____

(_____) (_____) _____

Home Phone _____ Cell Phone _____ Email Address (**Important**) _____

(_____) _____

Emergency Contact Person _____ Phone # _____ (If Minor) Parent/Guardian Name and Signature _____

Occupation _____ Employer Name _____ Phone # _____

• My condition is related to: Work Auto Accident (State _____) Other _____

Social Security # _____ Date of Birth _____ / _____ / _____ Single Married Divorced

Work Status: Currently Employed Retired Disabled (___ Total or ___ Temporary) Student (___ P/T ___ F/T)

2. Referral Info

*****"ALL INFO IS REQUIRED"
(PLEASE PRINT CLEARLY)****

How did you hear about us?
If by a friend or family member, please give their phone number and address below so we may send a thank you note and gift.

Referring Physician Name _____ Your Primary Physician Name _____

Street Address of Referring Physician _____

City _____ State _____ Zip _____

Phone # _____ Fax # _____

Do you have a follow-up appointment with this Physician? _____

If so, when? _____

3. Payment Info

(Check appropriate box or boxes)

PLEASE SELECT YOUR DESIRED PAYMENT METHOD.

Insurance: (Primary and Secondary)

- Medicare / Medicare HMO
- Medicaid
- PPO / Private / POS
- Worker's Compensation
- Auto Insurance
- VA Insurance
- Health Savings Account

Litigation / Lien: (**Note: Additional Paperwork Required)

- Auto
- Work Injury
- Other: (Specify) _____

Self Pay: (**Note: Self pay rate is a community service discounted rate we offer as a courtesy to our patients/clientele. Paperwork and Administrative costs may incur additional fees. Please discuss any concerns with Billing Manager or Office Manager)

- Cash Check (s)
- Credit Card Care Credit
- Payment Plan (Additional Fees May Apply)

4. Additional Info:

I fully understand that I am directly and fully responsible to said provider for all therapy and/or medical benefits submitted by provider for services rendered me and that this statement/document is made solely for said provider's additional protection. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court cost will be added to the total amount due.

Authorized Signature _____ Date: _____