

**METTLER THERAPY SERVICES
PATIENT REGISTRATION**

A. Patient:

Last: _____ First: _____ Social Security #: ____ - ____ - ____

Current Address: _____ City: _____ State: ____ Zip: _____

Permanent Address: _____ City: _____ State: ____ Zip: _____
(if different)

Home Phone: (____) ____ - ____ Work Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____

Male Female Age: ____ Date of Birth: ____/____/____ Email: _____

Reason for choosing Mettler Therapy Services: _____

Name of Mettler Therapist (if assigned/known): _____

B. Insurance:

If you would like Mettler Therapy Services to submit therapy charges to your insurance company, please complete the following:

Personal Health Insurance:

Subscriber Name: _____ Date of Birth: ____/____/____

Patient's relationship to subscriber: self spouse child other: _____ Phone: (____) ____ - ____

Please verify with your insurance company:

Do you need to receive pre-authorization from your insurance company prior to treatment? yes no

Have you received pre-authorization from your insurance company for treatment at Mettler? yes no

Do you have restrictions on how much therapy you may receive here? yes no If yes, what? _____

If your injury is accident-related (work, auto, or other personal injury/liability case), please complete the following:

Liability Insurance:

Work-related Auto Accident Other Accident/Injury Date: ____/____/____

Insurance Carrier Name: _____

Carrier Billing Address: _____ City: _____ State: ____ Zip: _____

Claim #: _____ Adjuster Name: _____ Adjuster Phone: (____) ____ - ____

If worker's compensation injury, please list company responsible for claims:

Employer: _____ Supervisor: _____ Phone: (____) ____ - ____

Employer Address: _____ City: _____ State: ____ Zip: _____

C. Provider Information:

Referring Physician: _____ Office Address: _____

Primary Care Physician: _____ Office Address: _____
(if different from referring)

D. Assignment of Medical Benefits:

I assign to Mettler Therapy Services all benefits payable to me for this care. I understand that this facility may be paid directly by the insurance company or other payer. I verify that all the above information is true and honest.

Patient Signature: _____ Date: ____/____/____
(Signature of parent or guardian if under 18 years old)