Patient Information

Patient Name:___________________________ Sex:______ D.O.B:___________ Marital Status:_________
Mailing Address:_________________________ City:__________________ State:_______ Zip:__________
Physical Address (if different): ___________________________ City: ______________Sate:____ Zip: ______
Social Security #______________________ Hm Phone:____________________ Wk Phone:____________________
Employer Name:____
Address:__________________________________ City:__________________ State:_______ Zip:_____________
Emergency Contact:____________________________________ Phone #:______________________________
Family Doctor: _______________________________ Referring M.D:____________________________________

Guarantor Information
(Person responsible for bill)

Guarantor Name: ____________________Rel to Patient: ___________ D.O.B: ____________ Marital Status: ________
Address: ______________________________City: _______________________State: ___________ Zip: ____________
SSN:_______________________ Home Phone: ____________________ Work Phone: ______________________
Employer Name:____ FT PT Are you in school? ______ FT PT
Address: ______________________________ City: _____________________ State: ____________ Zip: ___________

Insurance Information

Is this work related? _______
Primary Insurance Plan Name: ____
Insured Name: ______________________ SSN: ____________ D.O.B.: _____________ Rel to Patient: _____________
I.D. # ____ Group #: _________________
Secondary Insurance Plan Name: ____
Insured Name: ______________________ SSN: ____________ D.O.B.: _____________ Rel to Patient: _____________
I.D. # ____ Group #: _________________

Is Medicare your primary insurance? ________ If so, Why? ____

HIPAA:
Acknowledgment of Receipt of Notice of Privacy Practices

Our Notice of Information Practices provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms or our notice may change. If we change our notice, you may obtain a revised copy upon your next visit.

Designated Individuals Authorization Form

I hereby authorize one or all of the designated partied below to request and received the release of any protected health information regarding me treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

List Authorized Individuals and Relationship:
Name____________________________ Rel:________________ Name_________________________Rel_________________
Name____________________________ Rel_________________ Name_________________________Rel:_________________

Acknowledgment of Patient Payment Responsibilities

As a courtesy, we verify your insurance benefits prior to your appointment. Your insurance company was contacted and gave us the following information. We encourage you to contact your insurance company directly for verification that the information we received is correct. Copay Amount: _____ per visit. Limits on Physical Therapy Include: ____ visits per____

By signing below, I acknowledge that I received The Notice of Information Practices on the date indicated below, authorized one or all of the designated parties above to act as a Designated Individual within the stipulations listed above, and was counseled on my payment responsibilities in accordance to the billing policies and procedures.

____
Signature Date

Revised 01/16/2009