

Patient Information

Patient Name: _____	Sex: _____	D.O.B: _____	Marital Status: _____
Mailing Address: _____	City: _____	State: _____	Zip: _____
Physical Address (if different): _____	City: _____	State: _____	Zip: _____
Social Security # _____	Primary Phone: _____	Secondary Phone: _____	
Emergency Contact: _____	Phone #: _____	Are you in school? _____ FT PT	
Patient's Employer Name: _____	FT PT	Employer Phone Number _____	
Address: _____	City: _____	State: _____	Zip: _____
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: _____	Are you in school? _____ FT PT	
Employer Name: _____	FT PT	Employer Phone Number _____	
Address: _____	City: _____	State: _____	Zip: _____

Insurance Information			
Is this work related? _____			
Primary Insurance Plan Name: _____			
Policy Holder: _____	SSN: _____	D.O.B: _____	Rel to Patient: _____
I.D. # _____	Group #: _____		
Secondary Insurance Plan Name: _____			
Policy Holder: _____	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 of 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 parties below to request and receive the release of any protected health information regarding my 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 _____