PLEASE MAKE SURE YOU ANSWER ALL OF THE FOLLOWING QUESTIONS

PERSONAL INFORMATION

First Name: _____ M: _____ Last Name: _____ Gender: Male Female

Address: _____ City: _____ State: _____ Zip: _____

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

E-Mail: _____ DOB: _____/_____/_____ Soc. Sec. Number: _____-_____-_____

Occupation: _____ Employer: _____

Marital Status: Single Married Other Spouse's Name: _____ Phone: (_____) _____-_____

Who may we thank for referring you? _____

EMERGENCY CONTACT

Name: _____ Phone: (_____) _____-_____ Relationship: _____

HIPAA PHONE AUTHORIZATION

I _____ authorize PhysioCare Physical Therapy to leave a message with, or speak to the specified individual(s) listed below regarding my upcoming appointments, treatment related issues and account information. This authorization will remain in effect until you choose to revoke it. *Note: you do not have to fill this out if you would like your information to remain private.*

❑At my home number: (_____) _____-_____ with (name): _____

❑At another number: (_____) _____-_____ with (name): _____

NATURE OF INJURY/ SYMPTOM

Referring Physician: _____ Primary Care Physician: _____

Date of Injury/ Symptom: _____ Body Part Involved: _____ *Right or Left*

Cause of Injury: _____

INSURANCE INFORMATION

Primary Insurance:_____ Secondary Insurance:_____

ID Number: _____ ID Number: _____

Group Number: _____ Group Number: _____

Policyholder: _____ Policyholder: _____

Policyholder's DOB: _____ Policyholder's DOB: _____

WAS THIS WORK RELATED OR A MOTOR VEHICLE ACCIDENT? _____Yes _____ No

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize PhysioCare to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I agree to comply with the terms and conditions as outlined in the financial policy form. I hereby acknowledge that I have been offered a copy of the PhysioCare Notice of Privacy Practices.

_____ _____ _____

Patient Signature Parent/ Guardian Signature Date