Burk Physical Therapy and Rehabilitation
Patient Information

Please Print Clearly

Name: _____ Phone#: _____

Address: _____

City, State and Zip Code_____

Birth Date: _____ Age: _____ Social Security#: _____

Male __ Female __ Single __ Married __ Divorced __ Widowed __ Email:_____

Employer: _____ Phone#: _____

Employer Address: _____

Primary Doctor:_____Referring doctor:_____

Policy Holder or Spouse Information

Name: _____ Phone#: _____

Address: _____

City, State and Zip Code_____

Birth Date: _____ Age: _____ Social Security#: _____

Employer: _____ Phone#: _____

Employer Address: _____

Emergency Contact

Name: _____ Phone#: _____

*****Authorization, Assignment and Notice of Privacy Practice*****

I hereby authorize Burk Physical Therapy and Rehabilitation to furnish information to insurance carriers, employers and my attorney concerning my treatment. I further, irrevocably, assign to you and authorize direct said attorneys to pay from proceeds of any recovery in my case all reasonable fees for service provided by you, including fees for preparation. I understand that this in no way relieves me of my personal obligation to pay for such services. I understand that my signing this form does not prohibit customary billing by you or the submittal of any health and/or auto insurances. I understand and agree that (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I hereby assign to Burk Physical Therapy and Rehabilitation, all payments for medical services rendered to myself or my dependent. I certify this information to be true and correct to the best of my knowledge. I acknowledge that I have read and received the Notice of Privacy Practices from Burk Physical Therapy and Rehabilitation.

Signature: _____ Date: _____

******In lieu of patient signature, I _____, a staff member of Burk Physical Therapy and Rehabilitation, state that _____ has been given a current Notice of Privacy Practices.

Signature: _____ Date: _____

*****For Medicare Patients Only*****

I request that the payment of authorized Medigap Benefits be made either to me or on my behalf to Timothy P. Burk, P.T. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____