Hands On
Physical Therapy, PLLC

Name: ____ Male: ______ Female:______

Address: _____________________________________Birth date: ___________ Age: ______

City/State/Zip:____

E-mail: ____

Home Phone: _______________ Work Phone: ______________ Cell Phone: _______________

Insured Name: ____

Address (if different than above): ____

City/State/Zip: ____

Phone number: ____________________ Insured ID #: _________________________________

Emergency Contact Phone Number: ____

Name: ____

Open Labor & Industries/Workman's Compensation Claim: Yes: ___ No: ___
(Therapist cannot evaluate or treat and person with an open claim.)

Open Motor Vehicle Accident Claim or any other type of Claim: Yes: ___ No: ___
(Therapist cannot evaluate or treat and person with an open claim.)

MEDICAL RELEASE:

I, (print name)____ authorize Hands On Physical Therapy to release copies of medical records including chart notes, prescriptions and billing statements to anyone (i.e. insurance companies, physicians, lawyers) that I request or for whom I have signed a release form. The foregoing information is complete and accurate to the best of my knowledge, and on future visits I will inform Hands On Physical Therapy of any changes in my physical health.

Signature: ____ Date: _________________
Note: You are responsible for submitting your bills to the insurance company and payment is due at time of treatment.