Premier Physical Therapy:

Patient's Full Name: ____

Address: ______________________ City: ___________________ State: _____ Zip Code: _______

Home Phone: ________________ Cell Phone: ___________________

Date of Birth: __/__/__ Sex: M/F Student: Yes/No SSN (optional): _____________

E-mail Address: ______________________________

Emergency Contact: _____________________________ Phone: ________________________

How did you hear about us? ____

Parent/Responsible Party/Insurance Subscriber - if different from patient (Please CIRCLE all that apply)

Name: ____ Date of Birth: __/__/__

Address: __________________________ City: _______________State: _______Zip Code: _______

Phone: ____________________

Insurance Information:

Primary Insurance: ____________________ Secondary Insurance: ________________________

Subscriber: ____________ D.O.B. _______ Subscriber: ___________________ D.O.B. ________

Insurance ID: ________________________ Insurance ID: _______________________________

Group #: _______________________ Group #: _______________________________

Is this due to a motor vehicle accident? Yes / No

Is this a work related injury? Yes / No

Worker's Comp / Auto Insurance: _____________________ Adjuster: ________________________

Phone: _____________________Claim #: _____________Date of Injury: _____________________

Worker's Comp Only

Place of Employment: _____________________________ Phone: _________________________

Work Address: ____________________City: _______________ State: ____ Zip Code: __________

I authorize the use of the above information on my insurance claims. I understand that my signature authorizes that payment be made and that my medical information may be released in order to pay my claim. I understand that I am responsible for knowing my health insurance coverage. I understand that I am responsible for any DEDUCTIBLE or CO-PAY amount designated by my insurance contract or for services denied by my insurance. I request payment of authorized benefits be made on my behalf to Premier Physical Therapy for any services rendered. I understand that I am responsible for any unpaid balance on my account. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: __/__/__

Signature of Patient, Parent, Guardian or Legal Representative

Premier Physical Therapy

Patient Name: ____

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

It is the policy of this office to closely guard our patient's Protected Health Information. Unless otherwise indicated, the sharing of medical information will be restricted to the patient themselves (or his/her parents if a minor)

The patient may request that the people involved with their care be allowed to access his/her protected health information. Please list below any people with whom we may share your medical information. You have the right to amend this information at any time.

Please check all boxes when sharing of medical information is appropriate. Add any qualifiers or restrictions as required.

o Spouse Name:_______________________________________
o Children Name:_______________________________________
o Parent Name:_______________________________________
o Other – Please Specify Name: _______________________________________

Signature: ____ Date: __/__/__
Signature of Patient or Legal Representative

I give my permission for information to be left on my answering machine regarding physical therapy appointments.

Home Phone: ________________________ Cell Phone: _____________________________
Signature: ____ Date: __/__/__
Signature of Patient, Parent, Guardian or Legal Representative

Authorization for Medical Treatment
I hereby authorize the physical therapist in charge to administer treatment per determined place of care as deemed necessary according to the referring physicians/physical therapist's diagnosis.

The following signature verifies that I have read and fully understand the policies of Premier Physical Therapy and the HIPAA privacy notice.

Signature: ____ Date: __/__/__
Signature of Patient, Parent, Guardian or Legal Representative