PATIENT INFORMATION

Print Form

PATIENT # | REFFERING PHYSICIAN:

PATIENT NAME: Last Name: | First Name: | Middle:

Nickname: | Date of Birth: | Marital Status: ☐M ☐S ☐D ☐W

PHYSICAL ADDRESS

Street:

City: | State: Alabama | Zip:

Phone Number:

MAILING ADDRESS

Street:

City: | State: Alabama | Zip:

Cell Number:

INJURY INFORMATION

☐ Car Accident | ☐ Work Related | ☐ Accident | ☐ Other

Date of onset / injury:

Have you recieved Physical Therapy Services anytime this year ? ☐ YES ☐ NO If Yes, Where?

HOW DID YOU HEAR ABOUT US?

☐ Newspaper | ☐ Phone Book | ☐ Friend | ☐ Relative | ☐ Other

Social Security #: | Dr. License #:

EMPLOYER INFORMATION

Name:

Address: | City:

State: | Phone Number:

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Subscriber Name:	Subscriber Name:
ID Number: / Group #:	ID Number: / Group #:
Address:	Address:
Phone Number:	Phone Number:

SPOUSE / GUARDIAN INFORMATION

Name: | Phone Number:

Address: | Cell #: | Date of Birth:

SPOUSE'S EMPLOYER INFORMATION

Name:

Address:

Phone Number:

Dr. License #: | SSN #:

EMERGENCY CONTACT INFORMATION

Name:

Address:

City: | State: | Zip:

Ph. #: | Relationship:

OFFICE USE ONLY

Verified By:	Verified By:
# of Visits: / Deductible: / Co-Pay:	# of Visits: / Deductible: / Co-Pay:

CONSENT FOR TREATMENT

Consent is hereby given for patient to receive treatment from Eastern Shore Physical Therapy.

Patient Name: Signature:

Date: **(If patient is underage, this form must be signed by Parent or Guardian.)**

RESPONSIBLE PARTY & INSURANCE PATIENTS

As a courtesy to our patient's, we will file your insurance forms relating to the physical therapy services rendered by Eastern Shore Physical Therapy. However, since our professional services are rendered to you, not the insurance provider, you are ultimately responsible to Eastern Shore Physical Therapy for your financial obligations. Physical Therapy is usually paid under the Major Medical Portion of your insurance. Major Medical covers out-patient services and is usually subject to a deductible that is different from any hospital or physician office deductible. If a deductible is due, then the patient or responsible party must be responsible for the payment of the deductible or any co-insurance or co-pay to Eastern Shore Physical Therapy. Sometimes there may be a need for a service or equipment rendered to the patient that the insurance company will not cover and it will be the responsibility of the patient (or responsible party) to pay for this. We try to verify this with the insurance company first and inform the patient as soon as we know.

I have read the above statement and I am aware that I will be responsible for whatever my insurance company does not cover for my treatment at Eastern Shore Physical Therapy.

Patient or Responsible Party Signature:

Date: **(If patient is underage, this form must be signed by Parent or Guardian.)**

INSURANCE & MEDICARE PATIENTS

I authorize my insurance company, _____, to pay Eastern Shore Physical Therapy any medical benefits I may be due for services rendered. Authorization is given to release any information which may be necessary to process my insurance claims.

If my condition is work related, authorization is also given to my employer and / or workman's compensation insurance company for all medical information. In addition, my employer will be notified of any appointments missed without just cause.

Patient or Responsible Party Signature:

Date: **(If patient is underage, this form must be signed by Parent or Guardian.)**

THIS FORM MUST BE PRINTED OUT, SIGNED AND BROUGHT WITH YOU AT THE TIME OF YOUR APPOINTMENT.