

Doctors' Choice Physical Therapy

Patient Information

Account number: _____

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip code _____

Social security Number _____ Male Female

Home phone number _____ Martial Status M S W D

Cell number _____ Email _____

Occupation _____ Employer _____ Work phone _____

Address _____ City _____ State _____ Zip code _____

Who referred you to our office? _____

Health insurance Please present cards for copying

Primary insurance _____ Subscriber is same as patient Yes No

Subscriber's name _____ Date of birth _____

Id number _____ Group number _____

Secondary insurance _____

Subscriber's name _____ Date of birth _____

Id number _____ Group number _____

If auto accident: Auto insurance card (copy need)

Auto Insurance Name _____ Phone Number _____

Attorney name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

Claim Number _____ Adjuster's name _____

Please read and sign each of the following:

Consent to Treat:

I the undersigned, hereby authorize Doctors' Choice Physical Therapy and whomever they may designate as their assistants to perform diagnostic tests including but not limited to radiographs, and to administer treatment as is necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that my amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Authorization and release: I authorize payment of insurance benefits directly to Doctors' Choice Physical Therapy. I authorize Doctors' Choice Physical Therapy to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of case as determined by my treating doctor, any fees for professional services will be immediately due and payable.

The patient understands and agrees to allow Doctors' Choice Physical Therapy to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know that your Patient Health Information is going to be used by this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Privacy Notice that is available to you at the front desk before signing this consent. If there is anyone that you do not want to receive your medical records, please inform our office.

Patient's Signature _____ Date _____

Guardian's Signature Authorizing Care _____ Date _____