Pequot Lakes Physical Therapy Services. Inc.

Date _____ Clinic Number _____

Patient Name _____

Birth date _____ Age _____ Sex M/F

Address_____
(Street/P.O. Box) (City)

_____
(State) (Zip)

Home Phone _____ Cell Phone _____

Referring Physician _____

Type of Insurance _____

Social Security Number _____

Marital Status _____ Student: □ yes □ no

Employment Status _____

Employer _____

Phone Number _____

IN CASE OF EMERGENCY:

Name of Local Physician _____

Phone _____

Name of Spouse (parent if minor or significant other) _____

Date problem began _____

Were you injured at work: □ yes □ no Date _____

Claim Number _____

Were you injured in an auto accident: □ yes □ no Date _____

I agree to be responsible for any portion of my bill not covered by insurance. I understand and accept the responsibility of checking on my insurance benefits and complying with those requirements.

PEQUOT LAKES PHYSICAL THERAPY reserves the right to charge $25.00 for missed appointments or appointments cancelled without a 24 hour notice. Pequot Lakes Physical Therapy also reserves the right to discharge any patient, for any reason, including canceling and not showing for appointments.

I hereby consent to have physical therapy treatment. I certify that no guarantee or assurance has been made as to the result that may be obtained. I authorize my insurance company to pay directly to Pequot Lakes Physical Therapy. I authorize the release of medical records to either my attorney or insurance company upon written request. I have completed the patient information truthfully, and have read and understand the above statements.

The undersigned acknowledges that our Notice of Privacy Practices has been made available.

_____

SIGNATURE OF PATIENT DATE

If not signed by patient, relationship to patient _____

How did you hear about us?

Doctor_____ Phone book _____ Friend _____ Website_____

Other _____