Patient Information

Patient Name_____ Home Phone# _____Work_____

Address_____ Cell# _____

_____ _____ Birth Date_____

(State) (Zip Code)

Social Security #_____

Policy Holder Name_____ Relationship to Policy Holder_____

Referring MD_____ Co-payment Amount_____

Insurance Information

Is this a workers compensation case? _____ If so, date of injury_____

Employer's Name & Address _____ Phone #_____

_____

Is this a no fault case? _____ If so, date of accident_____ State _____

Insurance Carrier _____ Ins. Adjuster_____

Policy/Claim # _____ Phone # _____

Billing Address _____

_____

I authorize the release of any medical information necessary to process my insurance claim. I hereby assign payment of benefits from my insurance company to Pleasant Valley/Hyde Park Physical Therapy, but not to exceed the reasonable and customary charges for these services.

Patient Signature _____ Date _____

(Parent or guardian if patient is a minor)

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I have received and read a copy of the Notice of Privacy Practices.

Patient Signature _____ Date _____

(Parent or guardian if patient is a minor)