Integrated Physical Therapy Services

Patient Demographics

Name _____
(First) (Last) (MI)

Address _____
(Street) (City) (State) (Zip)

Phone _____ **Work** _____ **Cell** _____ **Email** _____

SS #_____ **DOB** ____/____/____ **Age** _____ **Gender M** _____ **F** _____

Emergency Contact Name & Phone _____

Referring Physician _____ **Date Last Seen** _____/_____/_____

INSURANCES (Check one)

☐**Private Insurance** _____ Policy # _____

Name of Policy Holder _____ Relationship to Patient _____ DOB _____

Secondary Insurance _____Policy # _____

☐**Workers's Comp** WC Claim # _____Date of Injury _____

Employer _____Address _____Phone _____

☐**Lien/Auto** Attorney Name _____

Address _____Phone _____

Auto Insurance Co. _____Policy #_____

☐**Self Pay**

Consent to Treat and Authorization to Release Information

INITIALS

_____I consent to *evaluation and treatment* by Integrated Physical Therapy Services and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I understand that I am financially responsible for Physical Therapy charges not covered by my insurance plan, or for the total charges, if no insurance applies.

_____I authorize the *release of information, as noted in the Statement of Privacy,* acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, and referring physician. A copy of ***Integrated Physical Therapy Services Statement of Privacy Notice*** has been provided to me.

_____I acknowledge that I have received the *waiver and release of liability form* and agree to the conditions listed within named waiver. I also agree to arbitrate any claims that may arise within the course of treatment I undertake with Integrated Physical Therapy Services, and the demands for arbitration must be communicated in writing to all involved parties.

SIGNATURE_____ **DATE**_____