



(1) PATIENT INFORMATION

NAME: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____ SEX: F M

Single Married Widowed Divorced PATIENT SS# _____

EMPLOYER: _____ Employer address: _____

Occupation: _____

Primary care Physician? _____

Referred by: _____

Have you been treated for this diagnosis before? If yes, when and where: _____

(2) CONTACT INFORMATION

HOME PHONE: _____

CELL PHONE: _____

E-MAIL: _____

WORK: _____ Extension: _____

Preferred method to contact? _____

IN CASE OF EMERGENCY, CONTACT:

HOME PHONE: _____ Relationship: _____

CELL PHONE: _____

WORK: _____ Extension: _____

E-MAIL: _____

(3) MEDICAL HISTORY

Please list any recent surgeries:

Surgery:	Date:

Please list any medications currently taking:

(4) LATE CANCELLATION POLICY

I acknowledge that there is a 24 Hour Cancellation Policy.

I will cancel within 24 hours or accept the responsibility for paying a cancellation charge of \$90.

SIGNATURE: _____

(5) Privacy Act Acceptance

I have read the HIPAA Privacy Act and am aware of my rights as a patient at

Equilibrium Physical Therapy, LLC

SIGNATURE: _____

INSURANCE AND ASSIGNMENT RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

And assign directly to Equilibrium Physical Therapy, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Date: _____

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Equilibrium Physical Therapy, LLC for any services provided to me. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claims. If other "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____

Date: _____