EQUILIBRIUM
PHYSICAL THERAPY

261 East 78th Street 2nd Floor
New York, NY 10075
P: 212-472-5820
F: 646-599-9617

(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:

☐ Check here if you would like to receive e-mails from Equilibrium PT about workshops, newsletters, and other related services.

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:_____