

PHYSICAL THERAPY & SPORTS INJURY REHABILITATION
PATIENT INFORMATION

PT / OT
Init.:
DX Code:

PLEASE PRINT

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Work Phone: _____

Zip Code: _____ Birth Date: _____ Age: _____ Social Security# (last 4 digits) _____ Sex: M / F

Referring Physician: _____ Primary Physician (HMO Physician) _____

In case of emergency contact – Name: _____ Phone: _____

PATIENT EMPLOYER INFORMATION

Employer: _____ Job Title: _____

Address: _____ City: _____ State: _____ Zip Code: _____

If you are NOT the policy holder listed on your insurance card, PLEASE complete the following:

Relationship to the Insured: Circle One Family Spouse Employee Other

Insured's Name: _____ Birth Date of Insured: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Social Security#(last 4 digits): _____ Employer of Insured: _____ Phone: _____

HOW DID YOU HEAR ABOUT PTSIR? (Please circle)

- | | | |
|---------------------|-------------------------------------|----------------|
| 1 Physician | 5 Friend | 9 Other: _____ |
| 2 Insurance Company | 6 Previous Patient | |
| 3 Yellow Pages | 7 Coach | |
| 4 Website | 8 Advertisement, Please List: _____ | |

Would you like to receive our monthly newsletter? E-mail address: _____

INJURY INFORMATION

Date of Onset/Injury/Surgery: _____ On the Job Injury? Yes No Auto Accident? Yes No Other: _____

Please read and Sign the following:

I hereby authorize release of any information, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, to the physician who referred me for therapy, and/or to any organization responsible for the payment of my account. At Physical Therapy & Sports Injury Rehabilitation, our goal is to have you return to your normal activities as soon as possible. Your attendance to physical therapy treatment sessions is most important for successful treatment. If you are unable to keep an appointment, we require that you provide PTSIR with a 24 hour notice. PTSIR has a \$25.00 fee for all appointments cancelled with less than a 24 hour notice or a no show. Insurance companies do not pay for this charge. Therefore you will be the party responsible for payment of the \$25.00 cancellation fee. Your signature acknowledges and agrees to this cancellation policy. A copy of this can be considered as an original for insurance purposes and valid as an original.

I hereby consent to such treatment procedures and patient care which in the judgment of my therapist, or physician, may be considered necessary or advisable while a patient at Physical Therapy & Sports Injury Rehabilitation.

Date: _____ Signature: _____