

**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. I acknowledge and understand that I am responsible for all of the charges for services rendered to me by Physical Therapy & Sports Injury Rehabilitation. Although I request that services be billed to the responsible organization on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by the responsible organization, I further agree to make arrangements for prompt payment of the bill. I hereby authorize the responsible organization to pay the proceeds of any benefits due to me directly to Physical Therapy & Sports Injury Rehabilitation. 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.

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 canceled 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.

Date: _____ Signature: _____