New Patient Information **Date:**_____ **Account No.**_____

Patient Name:_____ E-Mail Address:_____ Age:_____ Sex: M F

Social Security No:_____ Date of Birth:_____ Marital Status: S M W Home Phone:_____

Mailing Address:_____ City/State/Zip:_____

Employer:_____ Occupation:_____ Cell Phone:_____

Employer Address:_____ Work Phone Number:_____

Spouse (or parent, if minor):_____ Spouse or Parent Employer:_____

Contact Person Outside Home:_____ Phone No.:_____ Relation to Patient: _____

Referring Physician:_____ Primary Care Physician:_____

Attorney Name: _____ Attorney Phone No: _____ Date of Injury:_____

Billing Information (Please present insurance card)

Workers Comp____Auto Accident____Medicare____Blue Cross____Cigna____United Health____PHCS ____Other____

If you want us to bill under workers comp or for an auto accident, we will do so but we ask that you present us with your personal health insurance information as back up.

I do not wish to provide a copy of my private health insurance card. I realize that if my workers comp or auto claim should be denied that I would be responsible for any charges incurred. Please Sign_____

Primary Insurance:_____ Primary Insured:_____ Relation to Patient: _____

Primary Insured's Social Security No.:_____ Primary Insured's Date of Birth: _____

Primary Insured's Mailing Address: _____ City/State/Zip: _____

Secondary Insurance:_____ Subscriber Name:_____

Subscriber Date of Birth:_____ Subscriber Social Security Number: _____

DID YOU COME TO OUR CLINIC ON THE RECOMMENDATION OF YOUR PHYSICIAN? _____ YES _____ NO IF NO, BECAUSE OF _____ FRIEND _____ NEWSPAPER _____ YELLOW PAGES _____ ATTORNEY OTHER _____

CONSENT TO PHYSICAL THERAPY

1. **I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services and fully understand that I am financially responsible for any services not covered by this authorization.**

2. **I have presented myself to this facility for physical therapy treatments and consent to diagnostic procedures and care provided by my attending physical therapist. I authorize release of all information relating to this account/file to any person pertinent to this account including but not limited to insurance companies, employer, physician, attorney, case management firm or agent thereof.**

3. **I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.**

4. ****NOTE TO WORKERS COMP** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.**

5. **I understand I am contractually responsible for payment of my account in full and if my account has to be turned over to collections, I will be responsible for any collection fees, attorney's fees, court costs, and any other cost incurred to collect this account (not applicable for accounts covered by Workers' Compensation). I further understand that all accounts with checks returned unpaid will be assessed a fee of $25.00 and that interest will be charged on all overdue accounts at 12% APR.**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACITON.

_____ **DATE:**_____

SIGNATURE OF PATIENT (if the patient is a minor {under 18 yrs of age} parent must sign)

_____ **DATE:**_____

SIGNATURE OF WITNESS (OSPT Staff)