AUSTIN PHYSICAL THERAPY, PLLC
P.O. Box 157, 45 Stewart Avenue, Roscoe, NY 12776

PATIENT INFORMATION

(607)498-5653, (607)498-5671 FAX

Patient's Name_____DOB:_____Age:_____Sex: (circle) M F

Address_____City_____State_____Zip_____

Phone: Home_____Work_____Cell_____

S.S.#_____Marital Status (circle) M S D W E-mail address_____

Employer:_____Address:_____Phone:_____

Physician:_____Address:_____ Phone:_____

Have you had physical therapy in the past year? _____If yes, how many visits?_____

Who referred you to Austin Physical Therapy:_____

Authorization for Minor:

I give permission for my son or daughter_____to receive physical therapy.

Parent Signature:_____Date_____

INSURANCE INFORMATION:

Primary Insurance:_____Subscriber ID#:_____

Phone:_____Address:_____Group#_____

Secondary Insurance:_____ID#:_____

Phone:_____Insured S.S.#_____

ASSIGNMENT OF BENEFITS:

I authorize any holder of medical or other information about me, to release to the Insurance Company or Social Security Administration, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or to the party who accepts assignment.

I am ultimately responsible for any balance on my account for any professional services rendered that are deemed not medically necessary by Medicare or my insurance company.

I will notify you of any change in my health status or the above information. I also agree, understand, and authorize that my care and treatment will be carried out by the physical therapists at Austin Physical Therapy, PLLC. I have read all the information and certify this information is true and correct to the best of my knowledge.

Signature_____Date_____

CONTACT:

This permits Austin Physical Therapy, PLLC to release my confidential health information to the individual or individuals designated below. This is to include all information that pertains to treatment and payment at Austin Physical Therapy, PLLC

Contact Person:_____Relationship:_____Phone#_____

Patient Signature_____Date_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been asked if I would like to receive a copy of Austin Physical Therapy, PLLC Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed, and my rights with respect to my health information.

_____Yes, I request a copy

_____No, I do not want a copy

Patient Signature_____Date_____

Witness_____Date_____

Cancellation Policy: A $25 charge will be assessed for cancellations made without 24 hour notice, on the last business day, prior to the cancelled appointment. A charge will also be assessed for No Shows and for anyone more than 10 minutes late, requiring rescheduling.

Patient Signature:_____Date_____