Eschman Physical Therapy

Date: _____ Referring Doctor: _____

Patient Information

Last Name: _____ First: _____ M.I. _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____ Date of Birth: _____

Sex: M ____ F ____ Marital Status: M ____ S ____ D ____ W ____

Spouses Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Date of Injury: _____ Is this a Work Related injury? Yes ____ No____

Is this an Auto Accident related injury? Yes ____ No____

Attorney Name:_____ Phone: _____

Primary Insurance: _____

Secondary Insurance: _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Eschman Physical Therapy, LLC. regardless of participation in or out-of-network. I understand a 24 hour notice should be given for cancellations.

Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Signature: _____ Date: _____