All Sports Physical Therapy
Patient Information

Full Name:		DOB:___/___/_____	SSN:
Address:		City/State:	Zip:
Phone: (home)	(cell)	(work)	
Email Address:			Sex: M/F
Referred By:		Referring Physician Phone:	
Address:		City/State:	Zip:
Primary Care Doctor:		Office Phone:	
Address:		City/State:	Zip:

Condition Information

Is your condition due to an accident?	Date of Accident:	
Type of Accident: Auto/Work/Home	If other, please qualify:	
Did you file a claim? Y/N	Adjuster's Name: Claim #:	Adjuster's Contact Number:
Do you have an attorney?	Attorney's Name:	Attorney's Contact Number:
Please provide any additional information:		

Insurance Information

Primary Insurance

Primary Insurance Plan:	
Policy Holder Name:	
Relationship to Policy Holder:	
Employer of Policy Holder:	
ID Number:	In Network? Y/N

Group Number:	Phone:
Address:	
City/State:	Zip:
Medicare Replacement Plan? Y/N	Deductible in OOP? Y/N
Pre-existing Clause in Effect? Y/N	COBRA Plan? Y/N
Benefits Confirmed by:	Date:
Reference Number:	

Secondary Insurance

Secondary Insurance Plan:		
Policy Holder Name:		
Relationship to Policy Holder:		
ID Number:	Group Number:	Phone:
Address:		
City/State:	Zip:	

Primary Policy Holder/Responsible Party Information

Guarantor Name:		
Relationship to Patient:		
Date of Birth:	SSN:	Phone:
Address:		
City/State:	Zip:	

Patient Name:	Date of Birth:

Child Policy

Children not being treated for therapy are not be left in the waiting area unattended or without adult supervision. If you must take children to the back treatment area while you are having therapy, they must be able to sit down and not disrupt yours or any other patient's therapy. **Children are not allowed on therapy equipment or to use therapy items unless they are receiving therapy.**

Acknowledgement of receipt of notice of Privacy Practices

By signing below, I acknowledge that I have been offered or provided a copy of *All Sports Physical Therapy* Notice of Privacy Practices.

HIPAA Medical Information Release

Release of Information:

[ ] I authorize the release of information from *All Sports Physical Therapy*, including the diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

[ ] Spouse_____
[ ] Child(ren)_____
[ ] Other_____
[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages:

Please call: [ ] my home [ ] my work [ ] my cell number _____

If unable to reach me:
[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] do not leave a message
[ ] (other)_____

The best time to reach me is (*day*)_____ between (*time*)_____

Your signature below indicates:

1. You read and understand the Acknowledgement of receipt of Notice of Privacy Practices
2. You read and understand the Medical Information Release.

Patient Signature:	Date:
Witness:	Date:
Patient Name:	Date of Birth:

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	