

Patient Name: _____

PATIENT INFORMATION:

Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Patient Social Security #: _____

Home Phone: _____

Work Phone: _____

Mobile Phone: _____

E-Mail _____

Marital Status:

Single Married Div. Widowed Other _____

Referring Physician: _____

Primary Care Physician: _____

Occupation: _____

Employer's Name: _____

Emergency Contact:

Name: _____

Number: _____ Relationship: _____

INSURANCE INFORMATION

Please fill in the appropriate section:

Insurance Co. Name: _____

Policy #: _____

ID#: _____

MEDICARE

Secondary Insurance: _____

ID #: _____

NO FAULT

Date of Accident: _____

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Policy #: _____

Insurance Rep.: _____

Case #: _____

WORKERS COMPENSATION

Date of Accident: _____

Insurance Co. Name: _____

Insurance Co. #: _____

Policy #: _____

Insurance Rep.: _____

Case #: _____

SIGNATURES

Assignment and release

I, the undersigned, certify that I (or my dependent) have Insurance coverage with _____ and assign Gotham Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature (electronic or otherwise) on all Insurance submissions .

Signature: _____ Date: _____

Acknowledgment of receipt of Notice of Privacy Practices

I, _____ have received the Notice of Privacy Practices from Gotham Physical Therapy.

Signature: _____ Date: _____

*******MEDICARE PATIENTS ONLY*******

I request that payment of authorized Medicare benefits made on my behalf to Gotham Physical Therapy for services furnished to me by Gotham Physical Therapy. I authorize any holder of medical information about me to release to the Center for Medicare Services and its Agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

*******CANCELLATION POLICY*******

I, the undersigned understand that as a patient at Gotham Physical Therapy I must cancel my appointment at least 24 hours prior to my appointment. Failure to do so will result in a \$50 cancellation fee.

Signature: _____ Date: _____

OFFICE USE ONLY

Account # _____ Date Rec'd _____