

NEW PATIENT INFORMATION

Worker's Compensation Medicare: Current Home Health? Y N Auto Accident
Date of Injury _____ Date of Injury _____
Employer: _____

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Sex: M F Soc Security Number: _____

Marital Status: S M D W Name of Significant Other/Spouse: _____

Employer: _____ Employer's Address: _____

Responsible Party:
(If patient is a minor) Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Reason for your Visit? _____

Who referred you to our office? _____ Date you last saw the Doctor? _____

INSURANCE INFORMATION

First Insurance Company:

Name of Insured: _____ Social Security Number of Insured: _____

Group Number: _____ Policy Number: _____

Second Insurance Company:

Name of Insured: _____ Social Security Number of Insured: _____

Group Number: _____ Policy Number: _____

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to the Provider. I also authorize the Provider to release any information required by the insurer for said payment. I am financially responsible for non-covered services. I further authorize Manger-Harrington Physical Therapy, PC to access any part of my records from my physician's office for continuity of care purposes and/or for the adjudication of all claims relating to payment of services. Records may be accessed in hard copy or by computer. I fully understand that only staff with a "need to know" based upon their job function will have access to my records.

It is understood that my medical records and those acquired from other facilities with my permission, will be held in strict confidence and will not be released to any other party without my expressed written authorization.

I understand that should I default on payment of my account, and collection agency services be required, all costs of collections, including attorney fees will be added to the balance of my account.

X _____
Patient's Signature Date

I hereby authorize Manger-Harrington Physical Therapy, PC to photograph me and to store those photographs in my medical chart as part of my evaluation and/or treatment. I understand that said photographs will not be used for any purposes other than medical care and will not be released to any party other than those authorized by myself.

X _____
Patient's Signature Date