

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ SS#: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (____) _____ Work Phone: (____) _____ Sex: _____
Occupation: _____ Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

(Please complete all sections unless information is the same as the patient.)

Primary Insurance Carrier: _____
Primary Insurance Policy Holder's Name: _____ Relation: _____
Date of Birth: _____ SS#: _____ Home Phone: (____) _____
Occupation: _____ Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Secondary Insurance Carrier: _____
Secondary Insurance Policy Holder's Name: _____ Relation: _____
Date of Birth: _____ SS#: _____ Home Phone: (____) _____
Occupation: _____ Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____

We are pleased that you have chosen The Smith Clinic for Physical Therapy to treat you.
It is our policy to bill your insurance company as a courtesy to you. Please provide us with a current copy
of your insurance card and update your information as changes occur.

I hereby assign all medical benefits to which I am entitled, from insurance, Medicare or other health plans to The
Smith Clinic. I hereby authorize the release of any information, including a copy of my medical records to the physician who
referred me as well as any organization responsible for payment of my account. A copy of this assignment is to be considered
as valid original for insurance purposes.

I understand that The Smith Clinic will bill my insurance company or appropriate agency for me. I realize that I am
responsible for all charges that are incurred in my treatment. I understand that I am responsible for any health insurance
deductibles and co-payments and that payment is due at the time of service. If any payment is made directly to me for
services billed by The Smith Clinic, I recognize obligation to promptly remit the same. I hereby guarantee payment for any
and all services that are rendered to me that are not covered by insurance. In the event that payments are not made as
guaranteed, I understand that The Smith Clinic has the right to pursue any means necessary to collect money due and that I
will be responsible for any legal or court fees.

Patient Signature: _____ Date: _____
(If patient is under 18, parent must sign)



**The Smith Clinic for Physical Therapy
Patient Information Acknowledgement Form**

I have received a copy of and fully understand The Smith Clinic's Notice of Information Practices. I understand that The Smith Clinic may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that The Smith Clinic will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Smith Clinic's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date



EMERGENCY CONTACT

Please provide the name of a friend or relative that we may contact in the event of an emergency.

Name: _____ Relation: _____ Phone: (____) _____

I understand that The Smith Clinic will charge a \$20 fee for appointments missed without prior notification. Fee will be applied if two-hour notification is not given.

Signature

Date

How did you hear about The Smith Clinic? (Please check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Doctor Referral | <input type="checkbox"/> Friend/Family |
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Other _____ |

Please answer the following questions regarding your therapy.

1. Have you attended physical therapy, occupational therapy, or been seen by a chiropractor this year?
Yes ___ No ___

If yes, please answer the following. If no, please skip to question 2.

Were your treatments related to the same injury you are being treated for at The Smith Clinic?
Yes ___ No ___

How many treatments have you had? _____

2. Is your physical therapy treatment related to an accident involving a third party? Yes ___ No ___

If yes, please answer the following.

Date of accident: _____

Type of Third Party: Worker's Compensation ___ Motor Vehicle Accident ___ Other Accident ___

Do you have an attorney involved in your case? Yes ___ No ___