Personal Physical Therapy Services

Personal Issues... Personal Care

-Patient Registration-

Date_____ Patient Name: _____ Sex ☐M ☐F
Last First MI

Address: _____
Street City State Zip

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____ Social Security Number: _____

Birthdate_____ Age_____ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced ☐Minor

Spouse/ Parent Name: _____

Emergency Contact (Name & Phone Number): _____

Employer: _____ Employer Address: _____

Primary Care MD_____ Referring MD_____

Who may I thank for referring you? _____

-Primary Insurance-

Please present copy of all Insurance cards, Auto Insurance, Worker's Compensation, &/or Lawyer's information

Insurance Company Name (Primary)_____(Secondary)_____

Policy Holder _____ Birthdate: _____ Soc. Sec. #_____
Last Name First Name MI

Address & Phone Number (if different from patient): _____

-Assignment and Release-

I certify that I, and/or my dependent, have insurance coverage with the above listed insurance company(ies) and assign directly to Personal Physical Therapy Services, LLC and Jennifer A. Thibodeau, P.T. 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 authorized the use of my signature on all insurance submissions.

The above named provider may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, or Personal Representative Date