ENHANCED PHYSICAL THERAPY

510 Bradford St. Suite B

Today's Date:_____/_____/_____ **Seward, NE 68434**

PATIENT NAME: _____ BIRTHDATE: _____/_____/_____ AGE:_____
(FIRST) (M.I.) (LAST)

MAILING ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE: (____)_____ CELL PHONE: (____)_____

GENDER: M OR **F** **MARITAL STATUS:** S M W D **SSN #_____**

HEIGHT:_____ WEIGHT:_____

EMPLOYER: _____ EMPLOYER PHONE: (____)_____

ADDRESS: _____ CITY:_____ STATE:_____ ZIP:_____

SPOUSE'S NAME: _____BIRTHDATE:____/____/____EMPLOYER: _____

EMERGENCY CONTACT: _____ EMERGENCY PHONE: (____)_____
(OTHER THAN SPOUSE)

DID SOMEONE (OTHER THAN YOUR DOCTOR) REFER YOU TO OUR CLINIC? YES OR **NO**

IF YES, WHO?_____

IS TODAY'S VISIT DUE TO WORKMAN'S COMPENSATION? YES OR **NO**

IS TODAY'S VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES OR **NO**

IS TODAY'S VISIT DUE TO AN OTHER LIABILITY ACCIDENT? YES OR **NO**

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE COMPLETE THE FOLLOWING:

DATE OF ACCIDENT:_____ WHERE DID ACCIDENT OCCUR:_____

WHERE SHOULD WE SEND THE BILLING? _____(INSURANCE CO NAME)

_____(INSURANCE CO ADDRESS)

DO YOU HAVE A CLAIM NUMBER? _____

IF YOU ARE ON YOUR PARENTS' INSURANCE PLAN:

PARENT NAME: _____ DATE OF BIRTH:____/____/_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

HOME PHONE :(____)_____ EMPLOYER: _____

CONSENT FOR TREATMENT/ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION:

I understand that I have been referred to Enhanced Physical Therapy and authorize Enhanced Physical Therapy to provide rehabilitative services as per my referral and/or as developed, modified and progressed at the direction of Enhanced Physical Therapy clinicians and/or my physician. I also assign directly to Enhanced Physical Therapy all medical benefits payable by my insurance company or Medicaid or Medicare benefits. I authorize release of any records necessary to secure payment of benefits to my insurance company or Medicare or Medicaid.

SIGNATURE: _____ DATE: _____

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ACKNOWLEDGEMENT OF NOTICE OF PRIVACY RIGHTS AND PRACTICES:
I have received the Enhanced Physical Therapy notice of Privacy Rights and Practices.

Print patient's name _____

Signature of patient/parent/guardian_____ Date_____

IF YOU WOULD LIKE US TO RELEASE INFORMATION TO RELATIVES/FRIENDS/CAREGIVERS:
Please list specific family members or friends that we may give your health information to. You are not required to list anyone. These persons may be involved with your healthcare or payment relating to your healthcare. Enhanced Physical Therapy will only disclose information that is directly relevant to the person's involvement in your healthcare or payment relating to your healthcare. You may change this list at any time.

Print Name: _____Print Name: _____

Print Name: _____Print Name: _____

If no one is specified, Enhanced Physical Therapy staff may use their professional judgment when disclosing your health information. Enhanced Physical Therapy will generally disclose only to immediate family members which include: spouse, mother, father, step-parent, son, daughter, step-child, brother, sister, grandparents, and step-grandparents.