Demographics

Date: _____/_____/_____

Patient Name: _____ Date of Birth: _____/_____/_____ Male Female

Social Security #: _____ Employer: _____ Marital Status: S M W D

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

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

Email: _____

Date Last Seen by Doctor: _____ Follow Up Date: _____

Referring Doctor: _____ Family Doctor: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Please list any individuals we are authorized to speak with regarding your care / account: (Include the last four digits of their Social Security Number *or* their Mother's Maiden Name for verification purposes. Thank you.)

Name: _____ Last Four Digits of SSN# or Mother's M.N.: _____

Responsible Party

Name: _____ Relation: _____ Phone: _____

Address: _____ City / State: _____ Zip: _____

To the best of my knowledge, all of the above information is true and complete. I understand I am responsible to pay for all services rendered to me, and that I am willing to make specific arrangements to pay whatever part is not covered by insurance in a timely manner. **(PLEASE REMEMBER, INSURANCE IS CONSIDERED A METHOD OF REIMBURSING THE PATIENT FOR FEES PAID TO THE DOCTOR, AND IS NOT A SUBSTITUTE FOR PAYMEN**T). If this account is assigned to an attorney for collections and / or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. I hereby assign all medical benefits to which I am entitled to my physical therapist for services rendered to my dependent or me. This assignment will remain in effect until revoked, by me, in writing. A photocopy of this assignment is to be considered as valid as the original.

Patient Signature: _____ Date: _____

MEDICARE ASSIGNMENT / SIGNATURE ON FILE: I request that payment of authorized Medicare benefits be made either to me, or on my behalf to IN TOUCH PHYSICAL THERAPY AND SPORTS MEDICINE for any services furnished me by that medical / healthcare provider / supplier. I authorize the release of any holder of medical information about me needed to determine these benefits, or the benefits payable for related services, to the Centers for Medicare and Medicaid Services, formerly the Health Care Financing Administration, and its agents.

Signature: _____ Date: _____

Notice of Privacy Practices

_____ _____

Patient's Name (Please Print) **Date**

_____ _____

Patient's Signature (or Legal Representative) **Legal Representative's Relationship**

By signing I acknowledge I have received or been offered a copy of In Touch Physical Therapy and Sports Medicine Notice of Privacy Practices / HIPAA Privacy Act.

Office Use Only:

- ☐ A good faith effort was made to obtain the patient's acknowledgment of the receipt of the Notice of Privacy Practices.
- ☐ The patient's identity has been verified with driver's license, state identification, student identification, or other.

The following identifies the efforts made and the reason the acknowledgment was not obtained or the patient's identity was not verified:

_____

_____ _____

In Touch Physical Therapy and Sports Medicine Staff Member (Signature) Date