PATIENT INFORMATION – Please complete ALL sections

Date	Referring Physician:	Primary Care Physician:

PATIENT INFORMATION

Patient Last Name:	First:	MI:	Date of Birth:	Age:

Mailing Address:	City:	Zip:

E-Mail:	☐ Male ☐ Female	Main Phone # ☐ home ☐ cell ☐ work

Employer: (subscriber employer)	Address	Alternate Phone # ☐ home ☐ cell ☐ work

Emergency Contact (last name)	First Name ☐ parent ☐ spouse ☐ friend	Emergency Contact phone #

How did you hear about us? ☐ Medical provider ☐ Yellow pages ☐ Sign ☐ friend _____ ☐ other

INSURANCE

PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARD (if applicable)

INSURANCE REINBURSEMENT POLICY

Regardless of your insurance benefits, you are responsible for your bill. Benefits quoted are not a guarantee of payment. By signing this form you agree to sign benefits to be paid directly to Peninsula Physical Therapy.

TREATMENT AND BILLING AUTHORIZATIONS

The information provided by me is true to the best of my knowledge. I authorize Peninsula Physical Therapy to treat my dependent or myself

Release of my medical information regarding physical therapy treatment may be provided to my insurance company for the purpose of processing

my medical and also to appropriate medical providers of care for coordination of care

PRIVACY PRACTICES SUMMARY

By signing this form, I am acknowledging that I have the option to receive a copy of Peninsula Physical Therapy's statement of privacy practices, or have declined to receive a copy. I understand that I can get a copy of the aforementioned statement of privacy practices at any time upon request. The statement explains how we use and disclose health information. If for payment purposes your insurance company requests a copy of your medical records, we will release the requested records to your insurance company. For optimal treatment, we also share information regarding your injury/illness with your doctor. If for any reason you do not wish for either your doctor or insurance company to have copies of these records, or any party described in our privacy practices, you must inform Peninsula Physical Therapy in writing. Peninsula Physical Therapy may also release medical information about you to a family member or a friend involved in medical treatment or payment of the medical bills. Unless specified, Peninsula Physical Therapy may also leave messages at your home/work regarding appointments or if we need to contact you. By signing below, you are agreeing to the terms listed above.

Effective 5/1/09 for identity theft security, we are now required to obtain a copy of your valid drivers license and/or picture ID.

Patient / Guardian signature	**Date:**