



Patient Information:

Name: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Responsible Party Information (person responsible for payment if different from above)

Name: _____ Relationship: _____ Phone: () _____

Address: _____ City: _____ State: _____ Zip: _____ DOB _____

M F Marital Status: single married Undisclosed Employment Status: full pat-time retired student none

Date of next doctor visit: _____ Date pain began: _____ Date of Birth: _____

Home Number: _____ Work Number: _____

I request that all communication from PRPT @ SEFR be directed to: **home** **work**

SEFR may leave messages regarding appointments, scheduling, or other administrative questions **Y N**

Is this injury accident related? **Y N** Type of accident: **Work Car Fall Sports Other**

Employment Status: Full Part-time Retired Student None

Referring Physician: _____ Employer: _____

Insurance Information

Insurance Company: _____ Name of insured: _____

Insured's Employer: _____ DOB of Insured: _____

Insured's Social Security Number: _____

Worker's Compensation Information:

Employer's Name: _____ Employer's Phone Number: _____

Worker's Comp Insurance Company Name: _____

Worker's Comp Phone: () _____ Contact: _____

Claim/IC# _____ Date of Injury: _____

Emergency Information:

Name: _____ Phone Number: _____ Relationship: _____

Financial Responsibility: I understand that services received at Park Ridge PT @ SEFR are billed as a hospital setting. This may affect how your insurance pays. Park Ridge PT @ SEFR recommends you contact your insurance company to verify coverage. **Iontophoresis may be recommended by your physician/therapist, however, some insurances-ie BCBS, Aetna, etc-may not cover this charge. ** I understand I am responsible for any amount not covered by my insurance company.

Assignment of Insurance and/or Medicare benefits:

I assign, transfer and set over to Park Ridge Hospital and/or attending physician all of my rights, title and interest to medical reimbursement from any insurance and/or Medicare coverage I have. I understand that I am responsible for all deductibles, co-insurance and/or non-covered charges. I also understand that payment is due at time of service and that I am responsible for all amounts not covered by insurance and/or Medicare.

Credit Report: I authorize Park Ridge Hospital to obtain credit reports with respect to my credit history from one or more credit reporting agencies at any time regarding past, current, or anticipated transactions for services, whether or not such transactions may or will involve credit, a delinquent account, or an outstanding balance after discharge from Pt Services.

Medical Consent: I consent to be examined and treated by Park Ridge Hospital Physical Therapy @ SEFR.

Release of Information: I hereby authorize the hospital and/or therapists to furnish to insurance carriers information needed to process the claims in reference to services received at this facility.

Signature: _____ Dated: _____

(Please initial the above lines provided; acknowledging your understanding.)