Physical Therapy Institute

Patient Name: ________________________________ Date of Birth: ___________________

Home Phone #: (   ) ____________________ Mobile Phone #: (   ) __________________

Address: ____

City: __________________________ State: ___________ Zip Code: __________________

Occupation: ___________________________ Employer: _____________________________

Work Phone #: (   ) ___________________

Marital Status: Single Married Widowed Divorced Separated Partnered

Emergency Contact Name: ____________________________ Relation: __________________

Phone #: (   ) __________________ Address: _____________________________________

How did you find out about us?: Relative Friend Internet Physician Other

Physician's Name: ___________________________ Diagnosis: ________________________

*****ALL co-payments are due at the time of service*****

Catz Physical Therapy Institute is a teaching facility. As such, you may receive treatment from a Student of Physical Therapy which will be supervised by a licensed Physical Therapist. If you have any questions regarding the student program, please let us know before your evaluation. Thank you.

AS A COURTESY, WE WILL BILL YOUR INSURANCE COMPANY IF YOU PROVIDE THE APPROPRIATE INFORMATION. IT IS IMPORTANT THAT YOU UNDERSTAND THAT YOU ARE PERSONALLY RESPONSIBLE FOR ALL SERVICES RENDERED AT CATZ PTI AND THAT ALL FEES ARE CHARGED DIRECTLY TO YOU. WE ADVISE YOU TO CONTACT YOUR INSURANCE COMPANY AND INQUIRE SPECIFICALLY ABOUT YOUR PHYSICAL THERAPY BENEFITS.

With my signature, I consent to receive physical therapy treatment at Catz PTI. I also hereby authorize the release of medical information necessary to process the claim and authorize the payment of medical benefits to Catz Physical Therapy Institute.

Patient Signature: ____ Date: ______________

Parent/Guardian Signature: __________________________________ Date: ______________

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As required by the Health Information Portability and Accountability Act (HIPAA) of 1996 you have a right to request that communications concerning your personal health information be made through confidential channels.

I, ________________________________ hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment.

PHONE:
I prefer to be contacted at: (   ) __________________ Home Mobile Work Other

I **DO** / **DO NOT** want Catz PTI to leave messages on my answering machine
I **DO** / **DO NOT** want Catz PTI to leave messages with any other person

(if you selected **DO**) please indicate the name of any individual(s) approved to take messages:

____

MAIL:
I prefer to be contacted at the following address:

____

E-MAIL:
I prefer to be contacted at the following e-mail address:

____

Patient Signature: ____ Date: _______________

Parent/Guardian Signature: ___________________________________ Date: _______________