SHIPPENSBURG PHYSICAL THERAPY & SPORTS MEDICINE

General Information

Name: _____ Sex: _____Male _____ Female
(first, middle initial, last)

Address: _____

City: _____ State: _____ Zip: _____

Home/Contact Phone#: (_____) _____-_____ Cell Phone#: (_____) _____-_____

DOB:_____ Email Address: _____
(to receive correspondence and Newsletter, email will not be shared)

Additional Information

Referring Physician:_____ Family Physician:_____
Patient Employer: _____ Employer Phone#: _____
If there is **no** employer, please place a check next to the option that best describes your status below:
_____ Student _____ Disabled _____ Retired _____ Unemployed

***Since January 1ST of this year, have you had:**

PHYSICAL THERAPY? YES or NO
OCCUPATIONAL THERAPY? YES or NO
SPEECH THERAPY? YES or NO
CHIROPRACTIC CARE? YES or NO

Auto Related? YES or NO
Workers Comp Related? YES or No
Date of Injury:_____

*If you answered yes to any of the above questions, please indicate # of visits used: _____
(THESE THERAPIES MAY COUNT TOWARDS YOUR AUTHORIZATION OR PHYSICAL THERAPY VISIT LIMIT)

☐ **I attest that I have received, reviewed and understand what is outlined in the Notice of Privacy Practices.**

HIPAA: Other than the entities listed in the **Notice of Privacy Practices**, please list any names you give us permission to release or disclose health information to:

_____

_____

Emergency Contact Name and Phone:
(in case something were to happen to you here)

_____

_____

Insurance Information

So that we may ensure proper claims processing, please identify ALL of your insurance plan names below in addition to disclosing the identity of the policy holder for each plan.

Primary Insurance:	**Secondary Insurance:**	**Tertiary Insurance:**
_____	_____	_____
☐ **I am the policy holder**	☐ **I am the policy holder**	☐ **I am the policy holder**

POLICY HOLDER INFORMATION (Please complete this portion if you are NOT the Policy Holder)

Name:_____ Address (if different than yours): _____
Phone#: (_____)-_____-_____ DOB: _____/_____/_____
Employer:_____ Relation to the patient:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Shippensburg Physical Therapy & Sports Medicine. I understand that I am financially responsible for any balance and could be sent to collections with my failure to pay. I also authorize Shippensburg Physical Therapy and Sports Medicine to release any information required to process my claims.

Signature (Patient / Guardian): X_____ Date: _____