



Therapist

Date/Time

Welcome to our Center

PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

*Patient Name _____ * Referring Physician _____
 Address _____ City _____ State _____ Zip _____
 * Home Phone _____ Cell _____ * Primary Physician _____
 * Date of Birth _____ SS# _____ Sex _____ * Diagnosis _____
 Employer _____ Address _____
 City _____ State _____ Zip _____ Phone _____
 Emergency contact _____ Phone _____
 * Injury Result of Accident? Y OR N ***Work Comp? _____ **** Auto? _____ * Date of Injury _____
 * Have you had Physical Therapy before? _____ Where? _____ When? _____ Ins _____

*HEALTH INSURANCE INFORMATION

PRIMARY

Insurance Co. Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Group# _____
 I.D.# _____
 Subscriber (If other than patient) Date of Birth _____
 Name _____
 Relationship to patient Spouse ___ Parent ___ Other ___

SECONDARY

Insurance Co. Name _____
 Address _____
 City _____ State _____ Zip _____
 Phone _____ Group# _____
 I.D.# _____
 Subscriber (If other than patient) Date of Birth _____
 Name _____
 Relationship to patient Spouse ___ Parent ___ Other ___

***WORKMAN'S COMPENSATION INFORMATION

*Insurance Co. Name _____ *Claim# _____
 *Address _____ City _____ State _____ Zip _____
 *Adjustor _____ *Phone _____ * Ext _____
 *Employer at the time of Injury _____ Phone _____
 *Address _____ City _____ State _____ Zip _____
 U.R. Phone _____ Fax# _____

**** AUTOMOBILE INSURANCE INFORMATION

*Insurance Co. Name _____ Claim# _____
 *Address _____ City _____ State _____ Zip _____
 *Name of Insured (If other than patient) _____ Relationship _____
 *Adjustor _____ *Phone _____ Ext _____ Available PIP _____



FURNACE BROOK PHYSICAL THERAPY PATIENT AGREEMENT

As a condition of my treatment by Furnace Brook Physical Therapy (“FBPT”) I,
_____ (Please print name) agree to the following:

- 1) I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform FBPT of any changes to my insurance.
- 2) If FBPT does not receive insurance authorization for my treatment, I understand that I may sign an insurance waiver, which is valid for one treatment session.
- 3) I agree to pay any received co-payment at every visit, or in advance.
- 4) I will pay for any non-covered medical supplies (ie. Theratubing, Ionto pads) at the time of the disbursement.
- 5) I understand that treatment might be terminated if I cancel or no show for 3 appointments without rescheduling.
- 6) If my check is returned to FBPT for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat

- 7) I authorize FBPT to perform any therapeutic procedure or treatment that is consistent with my diagnosis. I understand that I will be given the opportunity to ask questions regarding my treatment, and that my physical therapist will be available to answer my questions. I understand that I can terminate any treatment at any time if I so desire.

Payment Guarantee

- 8) In consideration of the services rendered and to be rendered by FBPT, I expressly guarantee payment of my account and agree to pay and charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance.

Assignment of Benefits

- 9) I authorized payment directly to Furnace Brook Physical Therapy for services rendered.

Signature

Date