

Physical Therapy Services of Morristown, LLC

Patient Information Form (Please Print)

Patient Information				
Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip			Home Phone
Employer	Employer Address			Work Phone
Email Address				Cell Phone
Guarantor / Guardian Information (Responsible Party)				
Guarantor / Guardian Name	Sex	Relation to Patient	Date of Birth	Social Security No.
<input type="checkbox"/> Self				
Street Address	City, State, Zip			Home Phone
Guarantor / Guardian Employer	Employer Address			Work Phone
Other Information				
Referring Doctor (Name, Location)				
Family Doctor (Name, Location)				
Emergency Contact		Home Phone		Work Phone
Primary Health Insurance				
Primary Carrier Name		Mailing Address		
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.
Secondary Health Insurance				
Secondary Carrier Name		Mailing Address		
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.
Tertiary Health Insurance				
Tertiary Carrier Name		Mailing Address		
ID No.	Group No.		Employer	
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.
Workman's Compensation				
Carrier Name		Mailing Address		
Claim No.	Date of Accident		Adjuster's Name / Phone No.	
Automobile Accident				
Carrier Name		Mailing Address		
Claim No.	Date of Accident		Adjuster's Name / Phone No.	

Physical Therapy Services of Morristown, LLC

Consent for Care

I, the undersigned, do consent to physical therapy treatment administered by Physical Therapy Services of Morristown (PTSM).

Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this authorization. Our Notice provides a description of our treatment, payment, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this authorization.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I, _____, have received, read, and understand the Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I understand that PTSM has the right to change its Notice Of Privacy Practices and that I may contact the office at any time to obtain a current copy of the Notice.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment payment or healthcare operations. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Electronic Mail Consent

By providing PTSM with my email address I have agreed to receive information of future practice events via electronic mail. Information shall not contain any sensitive, confidential, or proprietary information. I understand that I have the option to un-subscribe to the list at any time by notifying PTSM.

Appointment Policy and Financial Agreement

I understand that twenty-four (24) hours notice is required to cancel an appointment. There will be a \$25.00 charge for canceling the day of the appointment and a \$40.00 charge for any no shows. I understand that if I am more that fifteen (15) minutes late for my appointment, I may not be seen.

I agree to pay to the order of PTSM all insurance benefits otherwise payable to us, but not to exceed the balance due for services rendered. I understand that the processing of insurance claims is a service and does not relieve me of my financial obligation. I agree PTSM may impose reasonable interest, late charges, cost and/or reasonable attorneys' fees should my account become delinquent.

Signature of Patient or Guarantor

Date

Name of Patient or Personal Guarantor

Relation to Patient