

PATIENT INFORMATION

PLEASE PRINT CLEARLY

NAME: _____

ADDRESS: _____

SOCIAL SECURITY #: _____

EMPLOYER: _____

ADDRESS: _____

DATE OF INJURY: _____

TODAY'S DATE: _____

BIRTH DATE: _____

PHONE: _____ WORK: _____

MARITAL STATUS: S M W D

OCCUPATION: _____

NEXT OF KIN, NOT LIVING WITH YOU - NAME _____ TEL. # _____

IS THIS A WORKER'S COMPENSATION CLAIM? Y _____ N _____

IS THIS CLAIM BEING SETTLED THROUGH AN ATTORNEY? Y _____ N _____

NAME: _____

ADDRESS: _____

WHO REFERRED YOU TO BERNIER PHYSICAL THERAPY? _____

PERSONAL MEDICAL INSURANCE

TYPE: _____

SUBSCRIBER: _____

(SECONDARY INSURANCE)

TYPE: _____

SUBSCRIBER: _____

INS. #: _____

RELATION TO SUB: _____

INS. #: _____

RELATION TO SUB: _____

DIAGNOSIS: _____

RELEASE OF MEDICAL RECORDS

I, _____, hereby consent to the release of any and all records and information, or copies thereof, from BERNIER PT ASSOC., INC. to _____'s physician, nurse, safety officer, rehabilitation specialist, or attorney when appropriate. I understand that regular reports will be sent regarding my treatment and progress.

SIGNED: _____

TODAY'S DATE: _____

— OVER —



SIGNATURE AUTHORIZATION

I authorize payment of medical benefits to BERNIER PHYSICAL THERAPY ASSOCIATES, INC. for services furnished to me by or in Bernier Physical Therapy Associates, Inc., including provider services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits.

SIGNED: _____

DATE: _____

CONSENT OF PAYMENT

I agree to meet all deductibles and co-insurance required by the policies of my insurance coverage. (Most insurances cover 80-100% of physical therapy after any annual deductible.)

I agree to pay these bills within 30 days of receipt of any insurance claim check or statements from this office.

SIGNED: _____

DATE: _____

CANCELLATION OF APPOINTMENTS

Twenty-four hours notice must be given in order to cancel an appointment, otherwise a \$25.00 charge will be billed to your account. INSURANCES DO NOT COVER THESE CHARGES.

SIGNED: _____

DATE: _____

