



# The Center

For Physical Therapy  
& Hand Rehabilitation

## PATIENT INFORMATION FORM

### PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE)		DATE OF BIRTH	MARITAL STATUS
ADDRESS (IF P.O. BOX, ALSO GIVE STREET ADDRESS)		HOME PHONE ( )	
CITY, STATE ZIP		SOCIAL SECURITY NUMBER	
EMPLOYER NAME	OCCUPATION	WORK PHONE ( )	
EMPLOYER ADDRESS (STREET, CITY, STATE, ZIP)			
REFERRING PHYSICIAN	DATE OF INJURY	DATE OF SURGURY	
DO YOU HAVE ANY OF THE FOLLOWING? PLEASE CHECK ALL APPLICABLE PACEMAKER ___ ALLERGIES ___ HEART DISEASE ___ METAL IMPLANTS ___ CANCER ___ PREGNANT ___ DIABETES ___ RECENT SURGERY ___			
IN CASE OF EMERGENCY CONTACT:		RELATIONSHIP	PHONE NUMBER ( )
SPOUSE'S NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
WHO IS FINIALLY RESPONSIBLE FOR THIS BILL?		I WILL BE PAYING TODAY BY? (CIRCLE) CASH CHECK VISA MC AMEX	

### INSURANCE INFORMATION

PRIMARY INSURANCE		PHONE NUMBER ( )	
NAME OF INSURED	RELATIONSHIP	I.D. NUMBER	GROUP NUMBER
SECONDARY INSURANCE		PHONE NUMBER ( )	
NAME OF INSURED	RELATIONSHIP	I.D. NUMBER	GROUP NUMBER

I, the undersigned, certify that I (or my dependent) have the above stated insurance coverage and assign directly to The Center for Physical Therapy and Hand Rehabilitation all insurance benefits payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Center for Physical Therapy and Hand Rehabilitation to release any information necessary to secure payment of benefits on all insurance submissions. Further, I authorize the release of my medical records from the office to either myself, or any and all medical personnel necessary for my continued medical care. In providing this consent, I am fully aware that the therapists of The Center for Physical Therapy and Hand Rehabilitation, the staff, and employees are released from any liability arising from such disclosure.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

## PATIENT AGREEMENT

### AUTHORIZATION FOR MEDICAL TREATMENT

Office Practice/Clinic personnel at this facility are hereby authorized to administer any medical or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

### DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by this Office Practice/Clinic and are accessible to office personnel. Office Practice/Clinic personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This Office Practice/Clinic and its medial staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier, or self-insured employer group liable for any part of the Office Practice/Clinic's charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that this Office Practice/Clinic advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). By signing this agreement, you are consenting to such disclosure. Office Practice/Clinic personnel may release my general condition to family or friends who inquire about me by name.

### ASSIGNMENT OF INSURANCE BENEFITS

I agree that therapist benefits otherwise payable to the insured are to be made payable to the therapist(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check, or credit card at the time of service.

### PRECERTIFICATION POLICY

I understand that this Office Practice/Clinic will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

### FINANCIAL RESPONSIBILITY

As consideration for the services provided, I (the patient or responsible party) guarantee payment for any amount due for such services provided by this Office Practice/Clinic.

### CERTIFICATION

I hereby certify that I have read each of the above statements, have had each item explained to me to my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

\_\_\_\_\_  
Patient or Patient's Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Account Number

### RELEASE OF PROTECTED HEALTH INFORMATION

Information may be released to the following individual(s)

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Phone Number

### ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this Office Practice/Clinic is in our NOTICE OF PRIVACY PRACTICES, which you have received. A copy is posted in this Office Practice/Clinic.

I have received a copy of Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Patient's Legal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness