PHYSICAL THERAPY • PERSONAL TRAINING

Patient Information

Today's Date	☐ Auto ☐ Worker's Comp ☐ Other	Area to be Treated	
Last Name	First Name, Middle Initial		
Street Address	Town	State	Zip Code
Home Phone	Work Phone	Cell Phone	Email
Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced	
Please remind me of appointments by: ☐ Email : _____		Please send me your newsletter ☐ Yes ☐ No	
Emergency Contact Name:	Phone	Relationship to Patient	
Employer		Occupation	
Employer Street Address	Town	State	Zip
Primary Care Physician Name	Phone #	Have You Had Therapy Before? ☐ Yes ☐ No	
Referring Physician Name	Phone #	If yes, when:	
Primary Health Insurance Carrier	Member ID#	Group #	
Primary Insured Name	Insured Date of Birth	Relationship to Patient	
Address (if different from patient)		Insured Phone #	
Secondary Health Insurance Carrier (if applicable)	Member ID#	Group #	
Primary Insured Name	Insured Date of Birth	Relationship to Patient	
Address (if different from patient)		Insured Phone #	
Worker's Comp/Auto Information (if applicable) Insured Name	Adjuster Name	Claim#	
Insurance Address and Phone #		Date of Injury	
Attorney Name, Address and Phone #			
Are you currently, or have you recently had home health services? ☐ Yes ☐ No	If yes are you still receiving service? ☐ Yes ☐ No		
	If no, when were you discharged?		
How did you hear about us?			

DPT Physical Therapy
27803 Woodward Ave, Berkley MI 48072
info@dptrehabfitness.com

CONSENT TO TREATMENT

I hereby authorize the professional staff at DPT Physical Thearpy to examine and treat me with Outpatient therapy for the injury I have been referred here for or referred myself to.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s) _____ . I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: DPT Physical Therapy for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**

AUTO INSURANCE CLAIMS

I hereby assign my right to collect no-fault insurance benefits to DPT Physical Therapy and affiliated healthcare providers for unpaid services from ___/___/___ to ___/___/___. This is not an assignment for benefits payable in the future or after the date of this document.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**

HIPAA REGULATIONS

I understand that DPT Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected. I have received a copy of the Notice of Information Practices.

_____	_____
Patient Signature	**Date**
_____	_____
Patient Printed Name	**Staff Witness Signature**
_____	_____
Parent or Guardian Signature (if under 18)	**Date**
_____	_____
Parent or Guardian Printed Name	**Staff Witness Signature**