

PATIENT INFORMATION

Name _____ DOB _____ Age _____
Address _____ City _____ ST _____ Zip _____
Home Phone _____ Business Phone _____ Cell _____
Occupation _____ Email _____ SSN# _____

EMERGENCY CONTACTS

Name _____ Relation _____ Phone _____

Name _____ Relation _____ Phone _____

Referring Physician _____ Phone _____

Primary Physician _____ Phone _____

Diagnosis/Injury _____

Work/Athletic Injury? Yes No If yes, Work/School name _____

Pertinent Past Medical History _____

Medications _____

Primary Insurance _____ Secondary Insurance _____

ID # _____ ID# _____

Subscriber _____ Subscriber _____

**** If Medicare, are you currently receiving any home services (visiting nurse, etc.)? Yes No**

How did you find out about South County Physical Therapy?

Name of Physician _____ Name of Friend _____ Other _____

Have you had PT, OT or speech therapy in the last 12 months? _____ If yes, please make front desk aware.

- I certify that all of the above information is correct.
- I authorize the release of any of the above information to my insurance company and I authorize my insurance company to **make payments on my behalf directly to:**

**South County Physical Therapy
319A Southbridge Street
Auburn, MA 01501**

I understand that any cost arising from physical therapy and NOT covered by my insurance company are my responsibility and that South County Physical Therapy may bill me for the balance(s). It is my responsibility to know what my benefit allows, including today's services (example: Blue Shield only allows one (1) evaluation per year/per body part). I acknowledge that I am expected to remit any outstanding balances within 30 days of billing.

- I hereby authorize physical therapy treatments by South County Physical Therapy.

Signature of Patient

Date