

**CONFIDENTIAL PATIENT INFORMATION**

(INITIAL EVALUATION) DATE: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(Please print)

Name \_\_\_\_\_ Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_

Email Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Sex: **M** **F** Age \_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital: **M** **S** **W** **D** How many children? \_\_\_\_

Employer \_\_\_\_\_ Employer's Address \_\_\_\_\_

Employer's Phone (\_\_\_\_) \_\_\_\_\_ Occupation \_\_\_\_\_

**Please inform us as soon as possible of any changes in your insurance information.**

**Payment is expected at time of visit.**

Name of insurance company \_\_\_\_\_

Insured's name (if other than patient) \_\_\_\_\_ Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Relationship to patient \_\_\_\_\_ Name of spouse \_\_\_\_\_

Name of referring physician \_\_\_\_\_

Date symptoms appeared or accident happened \_\_\_\_\_

Medical/Surgical history \_\_\_\_\_

Additional medical information \_\_\_\_\_

Attorney (Worker's Comp, MVA, Personal Injury) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Worker's Comp/MVA claim number \_\_\_\_\_

Adjuster \_\_\_\_\_ Adjuster Phone (\_\_\_\_) \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Relationship to patient \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**Name of person receiving treatment** \_\_\_\_\_

**Name of Responsible Party** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

*I understand and agree to pay all debts and outstanding balances for services rendered to the above designated patient, and that payment for these services, whether reimbursed by my insurance plan or not, or made at the time of service or at a later date, are my responsibility. While Parry Physical Therapy Group may assist me in verifying my insurance coverage, I realize that I am responsible to know my insurance benefits and coverage and am liable for all copayments, coinsurance and deductibles. If applicable, I acknowledge that I am responsible to endorse and surrender to Parry Physical Therapy Group, all insurance checks made out to me from my insurance company for physical therapy services. Further, if applicable, I grant this office permission to endorse checks made out to me, to be credited to my account.*

**Signature of patient or person responsible for payment** \_\_\_\_\_

**Informed Consent:** *I grant permission to Parry Physical Therapy Group for treatment in correspondence with either a medical prescription or a physical therapy plan of care, which may include, but is not limited to, therapeutic exercises, manual therapies and modalities. If treatment is rendered under direct access, I understand that I am required to see a medical doctor, DPM, or DDM, to continue treatment beyond the initial 30 days. In granting permission for treatment I release Parry Physical Therapy Group from any liability. I authorize payment of physical therapy benefits to Parry Physical Therapy Group for services rendered by Parry Physical Therapy Group. I authorize release of medical records upon request for settlement of a claim or for application of insurance benefits. I request payment of authorized benefits to be made on my behalf. I certify that information given by me in applying for insurance payment is correct.*

**Signature of patient or person responsible for patient** \_\_\_\_\_

Please forward all payments to: **Jack A Parry, PT, Inc. 361 S Eleventh Street, Ste 2, Quakertown PA 18951**