

PATIENT DEMOGRAPHIC FORM

Date: _____
Patient Name: _____
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Ph:() _____ Cell:() _____
Work:() _____ Ext _____
How did you hear about us? _____
Insurance: _____ Insurance Ph #: _____
ID #: _____ Group #: _____
Name of Insured: _____

****Complete Referral Summary****

Patient Social Security #: _____
Primary Physician: _____ Employer: _____
E-mail Address: _____ Permission to send information: Yes No
(Your email address is only for the use of Freedom Physical Therapy Services & will not be shared.)
If patient is under Mother's/Guardian Name: _____
18 years old: Father's/Guardian Name: _____
Address (if different than patient): _____

For Office Use Only

Insurance: _____ In Network Out of Network
What is the Deductible? _____ Met Not Met
At what percent do they pay? _____

Does a physician's referral need to be called in? No Yes _____
If not, do we need a physician's referral at all? No Yes _____
Is there a limit on visits? BMN or _____ # visits remaining _____
Do we need to pre-certify treatments? No Yes _____
Are orthotics covered? No Yes _____
Do we need to send in an Initial Evaluation? No Yes _____
Name: _____ Fax #: _____
Date: _____ Time: _____ Initials: _____

Please Note: You are responsible to know your level of coverage with your insurance company and whether you need to be pre-certified for any therapy treatment. As a courtesy to you, we do call on your benefits but we cannot guarantee the accuracy of the information we receive. You are responsible for any financial discrepancies that may occur if the benefits we are quoted are incorrect.

**Did you verify your insurance benefits after your initial phone call
with Freedom Physical Therapy? Yes No**

My benefit coverage has been explained to me. I understand I am financially responsible for any discrepancies.

Patient Signature

Date

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to Freedom Physical Therapy Services, the expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for physical therapy services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** A photocopy of this assignment shall be considered as effective and valid as the original.

In the case of personal injury, I instruct and authorize my attorney to pay direct to Freedom Physical Therapy Services, any monies due on my account, the same to be deducted from any settlement made on my behalf. Finally, no other third party, including my attorney, should receive payment of my medical bills except Freedom Physical Therapy Services for the duration of this claim.

I have read the above information and understand that I am responsible for payment of deductible, co-payment, and non-covered services as they are incurred. This information from my insurance company is not guaranteed and I hereby authorize Freedom Physical Therapy Services to bill my insurance company for all services rendered to me at this office. I understand that you will only bill by primary insurance and secondary insurance as necessary.

Release of Medical Records

I also authorize the release of any information pertinent to my case to any doctor, insurance company, adjuster, or attorney involved in this case.

Patient Signature (parent if under 18) Date

Patient Signature (parent if under 18) Date

Acknowledgement of Receipt of Privacy Practices

I have been offered the opportunity to review and to receive a copy of Freedom Physical Therapy's Notice of Privacy Practices with an effective date of January 1st, 2003. (This must be reviewed every calendar year).

Patient Name (printed) *Signature* *Date*

Patient Name (printed) *Signature* *Date*

Witness Name (printed) *Signature* *Date*

Witness Name (printed) *Signature* *Date*

**AUTHORIZATION AND/OR REQUEST FOR RELEASE
OF MEDICAL RECORDS AND/OR X-RAYS**



Print Patient's full name

Date of Birth

Authorize & Request:

(Name of party to release records)

(Address)

(City / State / Zip)

Please release the following (Check One):

Medical Records

MD office notes

MRI Report

CT Scan Report

X-Ray Report

Films (X-ray / CT / MRI)

Other (specify) _____

Purpose of Disclosure:

Physical Therapist Request

Other (specify) _____

Expiration:

This authorization expires on _____. If no date is specified,
then this authorization will expire one year from date of signature.

TO:

Freedom Physical Therapy

6908 N. Santa Monica Blvd

Fox Point, WI 53217

Fax: (414) 352-5279

1235 Dakota Drive, Suite K

Grafton, WI 53024

Fax: (262) 376-5156

19045 W. Capitol Dr, Ste 101

Brookfield, WI 53045

Fax: (262) 790-9893

Patient Signature (Parent/Guardian if under 18)

(Relationship to patient)

Date of Signing

This authorization shall be valid for procurement of records and reports of treatment rendered either before or after the date of this document. A copy of this Authorization shall be as valid as the original.