



Clay County Physical Therapy  
 117 South Saunders Ave.; PO Box 465  
 Sutton, NE 68979

PATIENT INFORMATION FORM

**THIS SECTION REFERS TO THE PATIENT ONLY**

|   |  |                          |                               |
|---|--|--------------------------|-------------------------------|
| <b>Name:</b> First _____ MI _____ Last _____  | <b>Sex:</b> Male <input type="checkbox"/> Female <input type="checkbox"/>  | <b>Birth Date:</b> _____ | <b>Age:</b> _____             |
| <b>Address (use PO Box if applicable):</b> _____  | <b>Marital Status:</b><br>Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> |                          |                               |
| <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____  | <b>Social Security:</b> _____  |                          |                               |
| <b>Home Phone:</b> _____ <b>Cell Phone:</b> _____   | <b>Emergency Contact:</b> _____  |                          |                               |
| <b>Email:</b> _____ <b>Work Phone:</b> _____  | <b>Relationship:</b> _____   | <b>Phone:</b> _____      |                               |
| <b>Employer:</b> _____  | <b>Student:</b> Full time <input type="checkbox"/> Part time <input type="checkbox"/> N/A <input type="checkbox"/>   |                          |                               |
| <b>Is injury work related:</b> Yes <input type="checkbox"/> No <input type="checkbox"/>   | <b>If accident Date of Injury or Onset:</b> _____  |                          | <b>Date of Surgery:</b> _____ |
| <b>Is injury accident related:</b> Yes <input type="checkbox"/> No <input type="checkbox"/><br>If yes was it an auto accident<br>Yes <input type="checkbox"/> No <input type="checkbox"/> | <b>Referring Physician:</b> _____  |                          |                               |
| <b>Diagnosis:</b> _____ <b>ICD-9:</b> _____   | Who can we "thank" for sending you to our clinic?<br>_____   |                          |                               |

**IF PATIENT IS A MINOR**

**Parent/Legal Guardian's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**  
 (Please have insurance card available for photocopy)

**Name of Insurance Company:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_ **Insureds S.S. #** \_\_\_\_\_

**Sex:** Male  Female  **INSURED'S BIRTH DATE** (Birth date of persons name on Insurance Card): \_\_\_\_\_

**ID #:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Patient Relationship to Insured:** Self  Child  Spouse  Other

**SECONDARY INSURANCE INFORMATION**  
 (Please have insurance card available for photocopy)

**Name of Insurance Company:** \_\_\_\_\_

**INSURED'S NAME:** \_\_\_\_\_

**Sex:** Male  Female  **INSURED'S BIRTH DATE** (Birth date of persons name on Insurance Card): \_\_\_\_\_

**ID #:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Insured's Employer:** \_\_\_\_\_

**Patient Relationship to Insured:** Self  Child  Spouse  Other

**Patient or Parent/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



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## PATIENT AGREEMENT FORM

### **CONSENT FOR TREATMENT**

I understand that I may have a condition requiring diagnostic procedures, physical examination and/or medical treatment. I hereby voluntarily consent to such procedures, physical examination and such clinical treatment as deemed necessary by my health care providers. I further acknowledge that no guarantees have been made to me as to the results of treatment or examination provided by Clay County Physical Therapy.

### **AUTHORIZATION FOR RELEASE OF INFORMATION**

The undersigned hereby authorizes Clay County Physical Therapy to release the patient's medical information to the referring physician, if any, and to the patient's health plan (such as Medicare, Medicaid, or insurance company) for the purposes of processing claims and to obtain payments for services provided to the patient.

### **MEDICARE RELEASE**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, and its agents, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made to Clay County Physical Therapy on my behalf.

### **MEDICARE SUPPLEMENTAL INSURANCE**

The undersigned hereby authorizes Clay County Physical Therapy to bill for Medicare Supplemental Insurance payments for my medical care. I understand that:

\_\_\_\_\_  
*(Name of Medicare Supplemental Insurance Carrier)*

may need information about me and my medical condition to make a decision about payment. I request the above named carrier to make payment of authorized Medicare Supplemental benefits on my behalf to Clay County Physical Therapy for any services furnished me and authorize any holder of medical information about me to release to the above named carrier any information required to determine and pay these benefits.

### **ASSIGNMENT OF INSURANCE BENEFITS**

The undersigned hereby agrees to assign and authorize payment directly to Clay County Physical Therapy of insurance benefits including liability insurance, otherwise payable to the undersigned or the patient, but not to exceed the office's regular charges for services.

### **FINANCIAL AGREEMENT**

The undersigned agrees that, in consideration of the services to be rendered to the patient, to Clay County Physical Therapy in accordance with the regular rate and office's payment policy. Please make all checks out to Clay County Physical Therapy.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING, HAS RECEIVED THE FINANCIAL & PRIVACY POLICIES, AND IS THE PATIENT OR IS DULY AUTHORIZED BY OR ON BEHALF OF THE PATIENT TO EXECUTE THE ABOVE AND ACCEPT ITS TERMS.

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date