NORTHTOWN BUFFALO PHYSICAL THERAPY, PLLC

PATIENT NAME: _____ AGE: _____ M/F

ADDRESS: _____ CITY _____ STATE ___ ZIP _____

PHONE: HOME (___) _____ CELL: (___) _____ DOB: _____

EMERGENCY CONTACT: _____ PHONE: ( ) _____

SOCIAL SEC. #: _____

EMPLOYER: _____ PHONE: (___) _____

ADDRESS: _____

INSURANCE CARRIER: _____ PHONE: (___) _____

ADDRESS: _____

POLICY HOLDER NAME: _____ DOB: _____

ADDRESS: _____

POLICY NUMBER: _____ GROUP #: _____

WORKERS' COMP CASE #: _____ CARRIER CASE #: _____

WORKERS' COMP INSURANCE CO: _____

ADDRESS: _____ PHONE: (___) _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. DATE OF INJURY/ACCIDENT OR DATE SYMPTOMS APPEARED: _____
2. PATIENT'S RELATIONSHIP TO POLICY HOLDER: SELF SPOUSE CHILD
3. WAS INJURY RELATED TO PATIENT'S EMPLOYMENT: YES NO
4. WAS INJURY THE RESULT OF AN AUTO ACCIDENT: YES NO

PHYSICIAN'S NAME: _____ PHONE: (___) _____

ADDRESS: _____

COMPLAINT/DIAGNOSIS: _____

PLEASE READ AND SIGN BELOW:

I authorize payment directly to Northtown Buffalo Physical Therapy, PLLC for services I receive. I agree I am primarily liable for all charges for services rendered by Northtown Buffalo Physical Therapy, PLLC and agree to pay all amounts not paid by my insurance carrier (s) for any reason. If I am claiming coverage under compensation or no-fault laws, I understand I am fully liable if such coverage is subsequently denied. I agree to supply major medical information in anticipation of such a denial.

I understand I may be charged a service charge for amounts not paid within sixty (60) days and in the event amounts are not paid when due, I agree to pay all reasonable attorney's fees and collection costs you may incur to collect such past due amounts.

I acknowledge receipt of a copy of Northtown Buffalo Physical Therapy, PLLC billing/insurance policy.

I give permission to Northtown Buffalo Physical Therapy, PLLC. to release any physical therapy information to my insurance company.

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE WITNESS DATE