OTTAUQUECHEE PHYSICAL THERAPY SERVICES

Patient Information

Name_____
Mailing Address _____
City/State/Zip _____
Physical Address _____
Phone (Home)_____ **(Cell)** _____
Date of Birth_____ **Sex: M / F Email**_____

Physician Information

Referring Physician_____ **Date Last Seen**_____
Primary Physician _____ **Date Last Seen**_____

Injury Information

Date of Onset/Injury_____
Automobile Related? Y N If so, State in which accident occurred_____
Work Related ? Y N Out of work date _____

Employer Information

Name _____
Phone_____**Contact Person**_____
Address_____

Emergency Contact

Name_____ **Relationship**_____
Address _____
Phone_____

Insurance Information: Please Provide Insurance Information at time of visit.

Primary Insurance Company Name: _____
Secondary Insurance Company Name: _____

Insurance Policy # _____ Insurance Group # _____
Secondary Insurance Policy # _____ Insurance Group # _____

IF YOU ARE PRIMARILY COVERED BY **MEDICARE**, MEDICARE REQUIRES THAT **EVERY 30 DAYS** YOUR PHYSICIAN CERTIFY THAT YOUR PHYSICAL THERAPY IS MEDICALLY NECESSARY. YOUR PHYSICIAN HAS THE OPTION TO REQUEST THAT HE/SHE ACTUALLY SEES YOU IN ORDER TO RECERTIFY TREATMENT.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Ottauquechee Physical Therapy Service to release any information requested with respect to the above referenced account to the extent necessary to determine liability for payment and to obtain reimbursement. **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct any payment of medical benefits to which I am entitled under Medicare and/or Private Insurance and/or other Health Plan(s), be made directly to Ottauquechee Physical Therapy Services. A photocopy of this authorization/assignment is to be considered as valid as an original. This assignment/authorization will remain in effect until revoked by me in writing to this assignee.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID FOR BY SAID INSURANCE.

AUTHORIZED SIGNATURE_____**DATE**_____