



Physical Therapy Institute
Dedicated to keeping you ACTIVE.

Patient Information Form

Patient Name: Home #: ()

Address: Mobile #: ()

City: State: Zip: Email:

Birthdate: SS#:

Patient Status: (please circle) Single Married Widowed Divorced Separated Partnered

Insurance Company:

Insurance Subscriber: Birthdate:

Employer:

Occupation: Phone: ()

Address:

City: State: Zip:

Emergency Contact: Relation:

Phone: () Address:

Referring Doctor: Diagnosis:
Reason for Therapy: (please circle) Home Related Work Related Auto Related Other
Type of Surgery: Date of Surgery:
Date of Injury:

IT IS IMPORTANT THAT YOU UNDERSTAND THAT YOU ARE PERSONALLY RESPONSIBLE FOR ALL SERVICES RENDERED AT CATZ PTI AND THAT ALL FEES ARE CHARGED DIRECTLY TO YOU. AS A COURTESY, WE WILL BILL YOUR INSURANCE IF YOU PROVIDE US WITH THE APPROPRIATE INFORMATION. PLEASE ALLOW US TO MAKE A COPY OF YOUR INSURANCE CARD FOR YOUR FILE. WE ADVISE YOU TO CONTACT YOUR INSURANCE COMPANY AND INQUIRE SPECIFICALLY ABOUT YOUR PHYSICAL THERAPY BENEFITS.

With my signature, I consent to receiving physical therapy treatment. I also hereby authorize the release of medical information necessary to process the claim and authorize the payment of medical benefits to CATZ Physical Therapy Institute.

Patient Signature: Date:

Parent/Guardian: Date:



At CATZ PTI, we have always kept your health information secure and confidential. We may disclose necessary health information for usual healthcare operations (payment of services, to contact you, physician, insurance carrier, etc.) or as required by law. We will not disclose your health information beyond the normal uses. A full notice of how your health information may be used and disclosed and how you can access or restrict this information is posted in our office and a copy will be made available to you upon request.

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my *personal health, treatment, or payment* of treatment. **This request supercedes any prior request for confidential channel communications I may have made.**

Please specify the means by which you would like to be contacted. Where you list more than one communication option, please indicate which you prefer.

DIAGNOSIS & TREATMENT

I, Do Do not want you to discuss my diagnosis and treatment with my family members.

Please indicate name, if any, of individual(s) approved for diagnosis and treatment discussion(s):

PHONE

I want you to contact me by telephone at: _____

Do Do not leave messages on my voice mail/answering machine.

Do Do not leave messages with any other person.

Please indicate name, if any, of individuals(s) approved to take above messages:

MAIL

I want you to contact me at the following address:

Please sign to acknowledge that you understand CATZ PTI's privacy practices.

Patient Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

I Do Do not want to be contacted regarding health programs, injury prevention classes, etc.