PROGRESSIVE THERAPY ALTERNATIVES - PATIENT INFORMATION AND CONSENT FORM

PT OT ST

For Office Use Only: Intake Date:_____ Appt Date / Time:_____

Therapist:_____ Diagnosis:_____

Referring Physician:_____ Pt Phone #:_____

FIRST NAME:_____ MI:____ LAST NAME:_____

ADDRESS:_____

SEX: M / F CELL #:_____ HOME #:_____ WORK #:_____

MARITAL STATUS: M S W D Sep. EMAIL ADDRESS:_____

DOB:_____ AGE:_____ SSN:_____ Date of Injury/Onset:_____

PRIOR TREATMENT: YES / NO - IF YES TO PRIOR TREATMENT, WHERE AND WHEN DID YOU RECEIVE THERAPY?:

_____

EMPLOYER (PATIENT OR PARENT'S):_____

EMERGENCY NAME AND PHONE NUMBER:_____

PRIMARY INSURANCE: WC MEDICARE BC/BS AETNA MMOH MEDICAID OTHER:_____

ADDRESS:_____ PRIMARY INSURED:_____

_____ EMP:_____ DOB:_____

PHONE: _____ CONTACT PERSON:_____

ID#:_____ GROUP#:_____

2ND INSURANCE: WC MEDICARE BC/BS AETNA MMOH MEDICAID OTHER:_____

ADDRESS:_____ PRIMARY INSURED:_____

_____ EMP:_____ DOB:_____

PHONE: _____ CONTACT PERSON:_____

ID#:_____ GROUP#:_____

****How did you hear about Progressive Therapy Alternatives?_____**

I wish to be contacted in the following manner (check all that apply):

Oral Communications:

( ) Home Phone _____ ( ) Cell Phone _____

( ) Ok to leave message with detailed information

( ) Leave message with call back number

( ) Other_____

( ) I permit the Practice to discuss my PHI with, and to disclose my PHI to the following individuals: ( ) Spouse_____

( ) Adult Children_____

( ) My Parent(s)_____

( ) Personal Rep._____

I have been offered a copy of the privacy act. _____ Initials

I acknowledge the above information is true to the best of my knowledge and give my permission for Progressive Therapy Alternatives to release information upon request to the referring and/or treating physician, insurance carrier, patient representative, or other entities who have direct affiliation with my medical care. I hereby authorize Progressive Therapy Alternatives to provide evaluation and treatment in accordance with the Plan of Care established in conjunction with the treatment and/or referring physician. I authorize payment directly to Progressive Therapy Alternatives and agree to pay any remaining patient balance.

Patient Signature_____ Date_____

(or parent/guardian signature)