EXETER HAMPTON PHYSICAL THERAPY
ORTHOPEDIC AND SPINE REHABILITATION

PATIENT RECORD FORM AND AGREEMENT **PLEASE FILL OUT COMPLETLY**

Patient Name: _____ Date of Birth: _____
Address:_____ Date of Injury: _____
City: _____State: _____Zip _____ SSN: _____
Home Phone _____Cell Phone _____ E-Mail _____
Work Phone _____Ext. _____

Primary Care Physician: _____
Referring Physician: _____

INSURANCE INFORMATION:
***Primary Insurance Company*: _____**
Name of Insured: _____Relationship to Patient: (Self__) (Spouse __) (Parent __)

Primary Card Holder's Name: _____ Date of Birth:_____

Secondary Insurance Company: _____Relationship to Patient: (Self__) (Spouse __) (Parent __)
Secondary Primary Card Holder's Name:_____Date of Birth:_____

EMPLOYMENT:
Employer: _____Occupation: _____
Address: _____
City: _____State:_____Zip _____
Employment Related Injury (Yes) (No)

Accident Related Injury (Auto) (Other) _____

How did you hear about our Clinic? ( ) Referred by MD ( ) Website
( ) Referred by Friend ( ) Phone Book

Direct payment on the day services are rendered is requested for any Instructional Visits and/or Short Term Therapy (2 visits or less). We submit claims to your insurance company as a courtesy to you. We request co-payment at the time of each visit for private insurance. You will be billed for any unpaid balance on your account.

Cancellation Policy: In order to serve you better and provide the best possible scheduling for our patients, we ask that you call us with your cancellation at least 24 hours prior to your scheduled appointment. No shows and late cancellations (less than 24 hours) will be charged a fee of $40.00.

I fully understand that I am responsible for all bills incurred while receiving treatment at Exeter Hampton Physical Therapy.

Signature: _____ **Date**: _____

Release of Medical Information to Insurance Company: I hereby authorize the release of medical information from my records at Exeter Hampton Physical Therapy to my Insurance Company

Signature: _____**Date**: _____

Authorized Payment: I authorize direct insurance payment of medical benefits to Exeter Hampton Physical Therapy for services provided.

Signature: _____ **Date**: _____