South Valley Physical Therapy, Inc. Established 1985

For Office Use Only	
M F	
Acct#	________________
Prim ICD10	________________
Therapist	________________
Ins. Type	________________

PATIENT INFORMATION
PLEASE FILL OUT COMPLETELY

Today's Date:____________________________

Name____ Age ______ Birthdate ____________________

Address____Apt______ City____________State____Zip________

Home ph_______________________________________ Cell ph ____

Referring MD______________________________**Date injury/onset/surgery**_________ **Body Part**_______________

Mandatory↑↑

Employer____work ph_________________________________

Primary Care Physician____

How did you hear about us?____

(MD, Internet, Insurance Company, Friend/Family)

EMERGENCY INFO: who should we contact in case of emergency?

Name____ Phone__________________Relationship_______________

PRIMARY INSURANCE INFO:

Insurance company________________________________ Group#_____________ ID#_________________________

Policy Holder____ Relationship________________________

Insured's Birthdate _______________________ Employer____

SECONDARY INSURANCE INFO: (if applicable)

Insurance Co_______________________________________ Policy Holder__________________________________

DOB______________Relationship____________________Group#_________ID#______________________________

WORKERS COMP INFO: (if applicable)

Insurance Carrier__________________________________ Adjuster____

Claim#____________________________ Phone#___________________ Fax_________________________

OVER PLEASE→

For Office Use Only:
Notes____
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Privacy Act

South Valley Physical Therapy is a HIPAA (Health Insurance Portability and Accountability Act of 1996) Compliant Practice

I have read and fully understand South Valley Physical Therapy's Notice of Information Practices (on clipboard) I understand that South Valley Physical Therapy may use or disclose my personal health information for the purposes of **carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment**. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that South Valley Physical Therapy, Inc will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted above. I understand that I retain the right to revoke this consent by notifying South Valley Physical Therapy in writing at any time. **If you would like a copy of our privacy act for your records please ask at the front desk.**

_______________________________________ _________________________________

Patient name (print) Signature

____

Date

If you would like email reminders regarding your scheduled appointments please provide us with your email address.

____________________________________@ __________________________________