STORY PHYSICAL THERPAY, INC.
AUTHORIZATION TO TREAT/PATIENT INFORMATION

NAME:____BIRTH DATE:______________

ADDRESS:____

CITY:_____________________________ STATE:_________________________ZIP:__________

EMAIL ADDRESS:____

HM PHONE: (____)___________CELL PHONE: (____)___________WORK PHONE: (____)__________

SOCIAL SECURITY #:_______________________ SEX: M F MARITAL STATUS: M S D W U

EMPLOYER:__________________________________ OCCUPATION:______________________

DATE OF INJURY:_________________________ DATE OF SURGERY:_____________________

REFERRING PHYSICIAN: ______________________ PRIMARY PHYSICIAN:__________________

HOW DID YOU HEAR ABOUT US? ___ MD Referral ___ Friend/Family ___ Advertisement ___ Other

PERSON TO CONTACT IN CASE OF EMERGENCY: _____________________________________

PHONE:____

PLEASE CHECK METHOD OF PAYMENT:
( ) CASH ( ) PRIVATE INS. ( ) MEDICARE ( ) WORK COMP
IF YOU HAVE MEDICARE, DO YOU HAVE SECONDARY INSURANCE POLICY? ( ) Y ( )N
PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARDS

WAS THIS A MOTOR VEHICLE ACCIDENT: ( ) Y ( ) N IF SO, PLEASE FILL IN THE FOLLOWING:

NAME OF MOTOR VEHICLE INS.:________________________ PHONE:_____________________

ADJUSTERS NAME:___________________________ CLAIM #:____________________________

NAME OF INSURED:____

**** PLEASE INITIAL THE FOLLOWING:**
___ I HEREBY AUTHORIZE STORY PHYSICAL THERAPY TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICAN.
___ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO WHICH I AM ENTITLED TO BE PAID DIRECTLY TO STORY PHYSICAL THERAPY. I UNDERSTAND THAT IF MY INSURANCE COMPANY/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYEMTN, THAT I AM RESPONSIBLE FOR THE BALANCE.
___ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECRODS TO STORY PHYSICAL THERAPY AND ANY PERTINENT INFORMATION CONCERNIGN THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.
___ I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY STORY PHYSICAL THERAPY. IF MY INSURANCE IS BEING BILLED, I WILL BE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. (THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS.)

____ **DATE**:______________________
SIGNATURE OF PATIENT/GUARDIAN