PATIENT INFORMATION

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Would you like appointment reminders? Yes No

Emergency Contact Name & Phone Number: _____

Relationship to patient? Spouse Parent Child Other _____

Do you have a Primary Care Physician? Yes No If yes, please provide: _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby authorize Northern Rehabilitation and Sports Medicine Associates, Inc. (NRSMA) to obtain or release all requested health information regarding care and treatment of myself or my dependents from/to insurance companies/workers comp insurance/employer and above-mentioned medical professionals. I also authorize payment to NRSMA of the medical plan otherwise payable to me.

I understand and agree that regardless of insurance status, I am ultimately financially responsible for full payment of services rendered to me or my dependents in this office. By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes. In addition, any unpaid balance after 90 days will be subject to interest charges of 1-1/2% per month or a minimum of $2.50 per month.

I consent to allow NRSMA's physical therapists and ancillary clinical staff to provide physical therapy examination and treatment procedures.

_____ _____

Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Our “Notice of Privacy Practices” provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this form. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by sending us a request in writing for a revised copy.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you are acknowledging receipt of Northern Rehabilitation and Sports Medicine Associates’ “Notice of Privacy Practices”.

_____ _____

Patient/Guardian Signature Date