Colleen M. Liaga Physical Therapy

Patient Information

Name _____ **Date**_____
Date of Birth_____ **SSN**_____ **Driver's License**_____
Address_____**Apartment/Suite**_____
City_____ **State**_____ **Zip Code**_____
Home Phone (_____)_____**Cell Phone(_____)**_____
Email address_____
Preferred Method of Communication: (please circle) Home Phone Cell Phone (call or text) Email
Sex (please circle) male female **Occupation** _____

Employer Name_____
Employer Address_____
City, State, Zip_____
Work Phone_____

Referring Doctor_____**Referring Doctor's Phone Number**_____
Date of Your Next Doctor's Appointment_____

Emergency Contact

Emergency Contact Name_____**Phone (_____)** _____
Relationship to Patient_____

Parent/Responsible Party

Please complete this section if patient is a minor or responsible party is different from patient.
Name_____**SSN**_____
Date of Birth_____ **Driver's License**_____
Sex (please circle) male female
Address_____ **Apartment/Suite**_____
City_____ **State**_____ **Zip code**_____
Home Phone (_____)_____**E-mail Address**_____
Relationship to Patient_____

Signed (Patient/Client)_____**Date**_____
Signed (Parent/Responsible Party)_____**Date**_____

INSURANCE (circle one): Medicare (add secondary below or write none)(BC/BS, Cigna, etc)
Reg Insurance Work Comp Personal Injury
PRIMARY INSURANCE:_____
Subscriber Name:_____
Insurance Phone Number:_____
Subscriber ID No:_____
Or claim number Ins Claims address_____

SECONDARY INSURANCE:_____
Subscriber Name:_____
Insurance Phone Number:_____ Subscriber ID No:_____
Ins Claims Address:_____

If Personal Injury/Legal:
Attorney Name:_____ Phone no:_____

Authorization to Release Information and Assignment of Benefits:
I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plan to Colleen M. Liaga Physical Therapy. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
Patient's Signature:_____Date:_____

Authorization of Release of Information:
I authorize the release of medical or any other information to the Health Care Financing Administration , my insurance carrier(s) or other entity necessary to determine insurance benefits or the benefits payable for related medical services and/or supplies provided to me by Colleen M. Liaga Physical Therapy. A copy of this authorization will be sent to the Health Care Financing Administration, my insurance carrier (s)m, or other medical entity, if requested. The original authorization will be kept on file.

My (new) insurance is:_____
Primary Care Physician:_____
Medical Group:_____

I understand that by signing this form, I am accepting financial responsibility as explained above for all payments for medical services and /or supplies received.

_____
Patient Name (Please Print)

_____
Insured Name (Please Print)

_____ _____
Patient/Insured's Signature Date