Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

● **PATIENT INFORMATION:**

LAST NAME _____ FIRST NAME & INITIAL _____

ADDRESS LINE _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____

WORK PHONE _____ SOCIAL SECURITY# _____

DATE OF BIRTH _____ AGE _____ MARITAL STATUS: S, M, D, W

REFFERRING DOCTOR _____ PHONE _____

EMERGENCY NOTIFICATION _____ PHONE _____

PATIENT'S EMPLOYER _____ OCCUPATION _____

SPOUSE NAME _____ WORK PHONE _____

NAME RELATIVE _____ PHONE _____

ATTORNEY NAME _____ PHONE _____

● **INSURANCE INFORMATION:**

CHIEF COMPLAINT _____ DATE OF INJURY _____

PRIMARY INSURANCE: HEALTH _____ AUTO _____ WORKER'S COMPENSATION ___ OTHER _____

INSURANCE CARRIER _____ PHONE _____

ADDRESS _____

CLAIM / ID# _____ GROUP _____

POLICY HOLDER _____

SECONDARY INSURANCE: HEALTH _____ AUTO _____ WORKER'S COMPENSATION ___ OTHER _____

INSURANCE CARRIER _____ PHONE _____

ADDRESS _____

CLAIM / ID# _____ GROUP _____

POLICY HOLDER _____

● **AUTHORIZATION TO PAY BENEFITS TO PROVIDER**: I hereby authorize my insurance company to pay any and all medical benefits directly to Manual Therapy Associates, Inc., if any otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. And I hereby authorize to issue any and all checks in Manual Therapy Associates, Inc. name. If my policy does not allow payment directly to the provider, I authorized payments to be issued with the payer being the above provider.

● **AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorized Manual Therapy Associates, Inc. to release any information acquired in the course of my treatment necessary to process insurance claims. I hereby consent to treatment as deemed necessary by the treating physical therapist(s) and referring physicians(s).

● **CANCEL / NO-SHOW**: Manual Therapy Associates, Inc. reserves the right to charge the patient or legal guardian $45.00 for a no-show charge for not canceling the patient's appointment at least 24 hours prior to the scheduled appointment.

I certify that I have read and understand the above hold harmless clause and release of information clause. The information I have provided on this form is true and correct to the best of my knowledge. A copy of this form is valid as the original.

X _____ **X** _____

Patient / Legal Guardian Signature Date