Hudson Valley Manual Physical Therapy

Patient Registration:

Name (Last):_____(First)_____: (MI):__Preferred Name:_____.
Date of Birth:_____Age:_____Gender:_____Height:_____Weight:_____.
Address:_____.
City:_____State:_____Zip Code:_____.
Home Phone:_____Work Phone:_____Cell:_____.
Email:_____Preferred Contact:_____.
Employer:_____Occupation:_____S.S. #:_____.
Emergency Contact:_____Phone:_____Relationship:_____.

Insurance Coverage: NO FAULT CLAIM

Primary Insurance:_____Secondary Insurance:_____.

Auto Case: Claim# _____.
Insurance co. name: _____.
Auto insurance claims address/phone#:_____.
_____
_____
Case Manager name & phone#_____.

Date of Injury:_____. Working? Yes or No

I understand that I am financially responsible for all charges including the balance remaining after payment of my insurance company (excluding no fault auto and workers comp). I authorize payment of medical benefit to Hudson Valley Manual Physical Therapy for professional services rendered. I also authorize any and all information concerning my physical therapy treatments may be sent to my insurance carrier in order to expedite payment.

Patient Signature:_____Date:_____.

Direct Access:

I have chosen to attend physical therapy by direct access (without MD referral). I am entitled to 10 visits and understand my insurance may not pay for these sessions. I assume responsibility for all physical therapy bills.

Patient Signature:_____Date: _____