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:

Primary Insurance:______________________ Secondary Insurance:
.
Identification #:_______________________________ Policy #:
.
Co-pay: Yes or No?________________ Amount:__________________________________.
Name & Date of Birth of Policy holder if not self:
.
Relationship to Insured:_____________________________________.

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:_______________.