



Moving you to wellness.

# MIDWEST PHYSICAL THERAPY AND SPORTS CENTER

## PATIENT INFORMATION

Please print clearly. Please complete all information for efficiency purposes. Thank you!

### OFFICE USE ONLY

Date of First Visit \_\_\_\_\_ Evaluating Therapist: \_\_\_\_\_ MPT Location: \_\_\_\_\_  New Patient  Update

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ (legal name)

(Preferred to be called: \_\_\_\_\_) Middle: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: M / F Marital Status: S M W D

Home Phone:(\_\_\_\_\_) \_\_\_\_\_ May we leave a message? Yes  No

Work Phone:(\_\_\_\_\_) \_\_\_\_\_ May we leave a message? Yes  No

Other Phone:(\_\_\_\_\_) \_\_\_\_\_ May we leave a message? Yes  No

Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student: No/Yes- School Name: \_\_\_\_\_ Full-time  Part-time

**Please let us know (in addition to spouse or guardian) whom we should contact in an emergency:**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Do you have: Medicare Coverage? Y/N Attorney working on your case? Y/N &/or Injured at work? Y/N

**(If you answered yes to any of the above questions, please inform the receptionist)**

### RESPONSIBLE PARTY OR SPOUSE INFORMATION

(Required if you are not the policy holder of insurance coverage)

**LEGAL NAME** Relationship to responsible party: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Date of birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Social Security #:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**PLEASE READ, SIGN AND DATE OUR FINANCIAL POLICY ON THE REVERSE SIDE OF THIS FORM ALONG WITH YOUR ACKNOWLEDGMENT OF RECEIPT OF OUR PRIVACY PRACTICES AS REQUIRED BY HIPAA.**

### OFFICE USE ONLY

WC  Auto  Liab'ty  Atty  MC  SP  HMO / POS / PPO



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## Acknowledgement of Receipt of Financial Policy and Assignment of Benefits

I, \_\_\_\_\_, acknowledge receipt of the Financial Policy from Midwest Physical Therapy & Sports Center (“Midwest”) and consent to the terms thereof.

I also hereby assign my rights to benefits and reimbursements now or hereafter due under my health insurance policy or policies for services provided to me by Midwest, specifically including the policy or policies identified on the insurance cards or certificates of coverage furnished by me to Midwest, and I authorize and direct all my insurance companies to pay the amounts due directly to Midwest. I certify that all information I have provided to Midwest is true and accurate to the best of my knowledge.

\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient/Guarantor Signature

## Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Midwest Physical Therapy & Sports Center.

\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Patient/Guarantor Signature

### OFFICE USE ONLY

In lieu of signature, I, \_\_\_\_\_, a staff member of Midwest Physical Therapy & Sports Center, state that

\_\_\_\_\_ has been given our Notice of Privacy Practices.

The undersigned attempted to obtain the patient’s written acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so because:

\_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature