Patient Information: Please Print

ept REHABILITATION

Diagnosis:_____ Onset/Injury Date_____
Referring Doctor_____

Patient's Name:_____ Home Phone_____

Mailing Address:_____ Message Phone_____

City:_____ State_____ Zip_____ Sex: M_____ F_____

Social Security #_____ Birth Date:_____ Age:_____
Responsible Party Name/Address:_____
Emergency Contact Name/Phone #:_____
If this case is litigated, please give your attorney's name, address and phone #:
_____
Current Employer/Phone #:_____

Insurance Information:

Primary Insurance: Medicare Part B _____Yes _____No Secondary Insurance:

Insurance Name:_____ Insurance Name:_____

Name of Insured:_____ DOB_____ Name of Insured:_____DOB_____

Are you a student? __ Yes __ No Who is the holder of the policy? ____ Self ____Parent ___ Spouse____ Other
Have you had HOME HEALTH SERVICES IN THE LAST 60 DAYS? _____Yes ____ No

Worker's Compensation Insurance:

Employer at time of injury:_____ Claim #_____

Compensation Carrier/Address:_____

Phone #:_____ Adjustor Name:_____

Medical Information: Do you have any of the following conditions:

Diabetes	___Yes ___No
High Blood Pressure	___Yes ___No
Heart Disease	___Yes ___No
Pacemaker	___Yes ___No
Headaches	___Yes ___No
Kidney Problems	___Yes ___No
Nervous Disorders	___Yes ___No
Allergies to Heat	___Yes ___No
Allergies to Ice	___Yes ___No
Other Allergies	___Yes ___No
Previous Surgery	___Yes ___No
Hernia	___Yes ___No
Seizures	___Yes ___No
IUD, Pregnant	___Yes ___No
Metal Implants	___Yes ___No

Others_____

Patient Information Consent and Receipt of Notice of Privacy Practices:

1. I, the undersigned give my consent for treatment and authorize the release of information to my physician and/or insurance company so my claim can be processed. I understand that I am financially responsible for physical therapy charges not covered by my insurance plan or for the total charges if no insurance applies.
2. I hereby acknowledge receipt of EPT Rehabilitation's Notice of Privacy Practices. EPT Rehabilitation will use or disclose my PHI (personal health information) for the purposes of carrying out treatment, payment and health care operations. The Notice of Privacy Practices contains detailed information about how the practice may use and disclose my confidential information.
3. I understand EPT Rehabilitation has reserved the right to change its privacy practices that are described in the notice. I also understand a copy of any revised notice will be posted in the office or provided to me upon request.
4. I hereby give EPT my permission to communicate with me through email and understand that email is an unsecure method of communication.
5. I give my consent for EPT Rehabilitation to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving EPT Rehabilitation written notice.

Signed:_____ Date:_____

If you are not the patient, please specify your relationship to the patient:

_____