COLLEEN HUFF & ASSOCIATES | StartClinic

Physical Therapy Center

*Date:*___________________________

Patient Information: ***Male___/ Female___***

Name: First _____________________ ***Middle___ Last*** _______________________ ***Date of Birth*** ____________

Street Address:____ City_____________________ Zip_________

Home Phone:______________________ Work Phone:__________________ Cell Phone:_______________

Employer:___________________________ Address:____

Employer Phone:_______________________ Occupation:____

SS#:__________________________________ Drivers Lic. #_____________________

Spouse Information: ***M___ Div___ DP___***

Name: First ___________________ ***Middle*** _______________ ***Last*** ____________

Employer:___________________________ Address:____

Employer Phone:_______________________ Occupation:____

Emergency information:

Person to contact in case of an Emergency: ____

Relationship to patient:__________________________________ Phone:__________________________

Was your injury an auto injury? Yes___ /No ___

Was your injury work related? Yes___ / No___

If yes, have your reported it to your employer? Yes___ /No___

Date of Injury:__________________________

Insurance information:

Primary Insurance:____

Insurance Company Address:____

Insured Name:______________________________________ Relationship to patient:__________________

ID#_________________________________ Group#_______________________ Claim#__________________

Insurance Company Phone:____________________________ Contact Name:_______________________

Authorization:

I hereby authorize ColleenHuff&Assoc to furnish information to my insurance carriers concerning my illness and treatments. I hereby assign and authorize payment of medical benefits to ColleenHuff&Associates for services rendered.

Signed: ____ ***Date:*** ________________________

I hereby authorize Colleen Huff to evaluate and treat my condition and/or illness with Physical therapy modalities and procedures.

Signed: ____ ***Date:*** ________________________

Office use: MD_____________________________ DX________________________________ ICD9______________