



# PRIVATE THERAPY SERVICES

PHYSICAL THERAPY

815 SAVANNAH HWY SUITE 101, CHARLESTON, SC 29407

PHONE: 843-766-2121 FAX: 843-766-8644

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_ ( ) Male ( ) Female

Employer \_\_\_\_\_ Address \_\_\_\_\_

Marital Status: Married ( ) Single ( ) Divorced ( ) Other ( ) Spouse \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

\*Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Reason for Physical Therapy: \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

\*Primary Insurance: \_\_\_\_\_ Address \_\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

\*Secondary Insurance \_\_\_\_\_ Address \_\_\_\_\_

Policy#: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

## Combined Authorizations:

I authorize physical therapy treatment as prescribed by my physician.

I certify that no guarantee or assurance has been made as to the results that may be obtained.

I authorize the release of any medical information needed to process my insurance claims.

I authorize all insurance benefits to be paid directly to Private Therapy Services.

I understand that I am financially responsible to pay any deductible, co-pay or co-insurance amounts due according to my health insurance contract. If my personal balance is not paid in full, I understand I am responsible for any associated legal or collections fees.

I give my permission for Private Therapy Services to leave messages on my home phone, and speak with anyone who may answer.

I give my permission for Private Therapy Services to leave messages in my work and cell phone voice mail.

I attest a Notice of Information Practices (Medical Records Privacy Policy) has been provided to me, as required by HIPPA regulations.

I hereby certify that I read and fully understand the above authorizations.

Signed: \_\_\_\_\_ (Seal) Date: \_\_\_\_\_

\*If Minor Signed by Mother ( ) Father ( ) Guardian ( ) Name \_\_\_\_\_