MAC PHYSICAL THERAPY

PATIENT INFORMATION

Last name:	First:	Middle Initial:		
Street address:		City:	State:	Zip:
Birth date:	Social Security #:	Gender: ❑ M ❑ F	Marital Status (Circle one): Married / Divorced / Widowed / Single	Spouse's Name:
Home Phone:	Cell Phone:	Email Address:		
I hearby give permission for MAC Physical Therapy, PLLC to: • Text Appointment Reminders ❑ Yes ❑ No • Send me email messages ❑ Yes ❑ No • Leave a detailed message on my voicemail/answering machine ❑ Yes ❑ No		❑ I would not like to be emailed updates about MAC Physical Therapy news and events		
Employer:	Employer's Address:			
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Peak Health and Wellness ❑ Other_____				

VISIT INFORMATION:

Reason for Visit:	Allergies:
Referring Physician:	Primary Care Physician:
Are you currently receiving any home health services? ❑ **Yes** ❑ **No**	

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Phone Number:

RESPONSIBLE PARTY INFORMATION

(Please fill out if the patient is a minor or if you have the power of attorney)

Last name:	First:	Middle Initial:	Relationship to Patient:	
Street address:		City:	State:	Zip:
Birth date:	Social Security #:	Home Phone:	Cell Phone:	Email Address:
Employer:	Employer's Address:			

INSURANCE INFORMATION

Primary Insurance: ❑ Information is the same as insurance card on file

Subscriber's name:	Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			
Secondary Insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

ASSIGNMENT OF INSURANCE BENEFITS / CONSENT TO TREATMENT

I authorize payment of insurance health benefits to be paid directly to MAC Physical Therapy, PLLC. I also consent to treatment by the health care providers of this medical practice. I understand that professional services at MAC Physical Therapy, PLLC, are contingent upon my compliance with the recommended treatment plan. I have listed all medical insurance for which I am eligible to the best of my knowledge and will notify of any changes in my health coverage. I also hereby authorized the release of information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that the balance on my account with this office is my responsibility whether my insurance company pays or not. I understand that should my insurance company reimburse me directly, then I will pay MAC Physical Therapy, PLLC within ten (10) days of the receipt of the payment. I understand that I will be responsible for paying any additional fees if my account gets sent to a collection agency. I understand that I will be assessed a $50.00 charge for any checks returned by the bank, and I will be reported to the local district attorney's office for checks not paid within two (2) weeks of being returned to the office. I release MAC Physical Therapy, PLLC, from any and all liability incurred as a result of the medical treatment provided by the staff of MAC Physical Therapy, PLLC.

NOTICE OF PRIVACY PRACTICES / PATIENT ACKNOWLEDGEMENT

The undersigned also acknowledges that he/she may receive a copy of the "Notice of Privacy Practices" at any time. MAC Physical Therapy, PLLC, will administer the patient records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. A separate authorization must be executed for the non-routine release of Protected Health Information. Patient information shall not be sold to any outside marketing firm and will not be included in any medical studies without the explicit and separate authorization of the patient.

Signature Required: _____ Date:_____