

MERZ PHYSICAL THERAPY

DATE _____

M S W D SP (Marital Status) M F (Sex)

Account # New Update

PATIENT NAME _____ Birthdate _____
(Last) (First) (Initial)

Address _____ City _____

State _____ Zip Code _____ How long at residence? _____

Social Security Number _____ (For billing purposes)

Home Phone Number _____ Work/Cell _____

Employer _____ How long? _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Birth date _____

Address (if different) _____ Phone _____

Employer _____ Phone _____

Who referred you to our office? _____

Who should we notify in a case of an emergency? _____

Relationship to this person _____ Phone _____

INSURANCE INFORMATION

Primary Insurance	Secondary Insurance

Records Release: I hereby authorize the release of any information, including medical and billing information to my referring doctor, insurance company, the responsible party named above, and immediate family on behalf of myself and/or dependants.

Guarantee of Account: I understand that medical insurance policies are an arrangement between and insurance carrier and myself. I understand that charges for some services may be more than what some insurance companies choose to call "usual and customary" and that unless I am covered by and in compliance with a health plan which Merz Physical Therapy has a participation agreement to provide covered services, that I am responsible for all charges applied to my account.

Assignment of Benefits: I hereby authorize Medicare benefits and other insurance benefits to be paid on my behalf to Merz Physical Therapy for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Date _____ Signed: **X** _____