ADMISSION RECORD

FORM COMPLETION INSTRUCTIONS:

- Please answer all questions (**Please enter N/A if not applicable**)
- All information will remain strictly confidential
- Questions, please ask our office associate

Patient Name:			Patient Date of Birth	Social Security Number
Mailing Address (No. & Street, Apt., etc.)			E-Mail Address	
City	State	Zip Code	Gender: Female Male	
Home Phone Number ( )	Work Phone Number ( )		Cell Phone Number ( )	
Primary Insurance Carrier Name			Secondary Insurance Carrier Name	
Insured's relationship to you □ Self □ Parent □ Spouse □ Other			Insured's Name (Who carries insurance contract)	
Insured's Employer Name:			Insured's Employer Address:	
City	State	Zip	Employer Phone Number:	
Insured's Date Of Birth:			Emergency Contact and Phone	
Marital Status: □ Single □ Married □ Divorced □ Widowed			Your occupation:	
Spouses Name:			Spouses Date of Birth	Social Security Number
PRIMARY CARE Physician Name			Phone Number	Date of Next Office Visit
REFERRING Physician Name			Phone Number	Date of Next Office Visit
I was referred to OCPT by:				

PATIENT AUTHORIZATION AND RESPONSIBILITY

I hereby consent to treatment at Ortho Care Physical Therapy, Inc. By consenting to treatment I authorize, on behalf of any covered family member or myself, direct billing of my insurance company and direct payment to Ortho Care Physical Therapy, Inc. By consenting to treatment, I also consent to the release of necessary medical information needed for the processing of the insurance claims, including release to any entity for the continuation of my medical care. I understand that a photocopy of the release is as valid as the original. In the event that my insurance company does not pay or partially pays on behalf of any covered family member or myself, I understand that it is my financial responsibility to remit payment in full to Ortho Care Physical Therapy, Inc. upon completion of the treatment session or within 10 days thereafter. I further understand that if the matter is referred to an attorney for collection, I will be responsible for the attorney's fees and court costs.

Signature of Patient, Guardian/Parent	**Date**

ORTHO CARE PHYSICAL THERAPY, INC.

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _____, have received a copy of the Ortho Care Physical Therapy Inc. Notice of Privacy Practices.

_____ _____

Signature of Patient Date

Revised 11/12/2014