YORK PHYSICAL THERAPY
2835 NORTH NEBRASKA AVE.
YORK, NEBRASKA 68467

NAME:_____ **DATE OF BIRTH:**_____ **AGE:**_____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS:_____**CITY:**_____**STATE:**____

ZIP:_____ **GENDER: M OR F** **E-MAIL ADDRESS**:_____

HOME PHONE:(_____)_____ **CELLULAR PHONE:(_____)**_____

MARITAL STATUS: S M W D **SS #**:_____ **EMPLOYER**:_____

EMPLOYER ADDRESS:_____ **EMPLOYER PHONE:(_____)**_____

SPOUSE'S NAME:_____ **SPOUSE CELLULAR PHONE:(_____)**_____

SPOUSE'S EMPLOYER:_____ **INSURANCE SUBSCRIBER DATE OF BIRTH**_____

EMERGENCY CONTACT (OTHER THAN SPOUSE):_____
(NAME)

EMERGENCY PHONE:(_____)_____ **EMERGENCY CELLULAR PHONE:(_____)**_____

IS TODAY'S VISIT DUE TO WORKMAN'S COMPENSATION? YES OR NO **DATE OF INJURY**_____

IS TODAY'S VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES OR NO **DATE OF ACCIDENT**_____

REFERRING PHYSICIAN:_____

IF YOU ARE A MINOR OR COLLEGE STUDENT:
PARENTS NAME:_____ **ADDRESS:**_____

CITY:_____ **STATE:**_____ **HOME PHONE(_____)**_____

PARENTS EMPLOYER'S:(FATHER)_____ **PHONE:(_____)**_____

(MOTHER) _____ **PHONE:(_____)**_____

CONSENT FOR TREATMENT / ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION
I understand that I have been referred to York Physical Therapy, Inc. and authorize York Physical Therapy, Inc. to provide rehabilitative services as per my referral and/or as developed, modified and progressed at the direction of York Physical Therapy, Inc. clinicians and/or my physician. I also assign directly to York Physical Therapy Inc. all medical benefits payable by my insurance company or Medicaid or Medicare benefits. I authorize release of any records necessary to secure payment of benefits to my insurance company or Medicare or Medicaid.

MEDICARE PATIENTS ONLY: CERTIFICATION AND FINANCIAL AGREEMENT – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed for this or a related Medicare claim. I request that the payment for authorized benefits be made directly to York Physical Therapy on my behalf. I understand that I am responsible for any medical insurance deductible and co-insurance, and for the cost difference of any private accommodation in which I am placed at my own request.

I understand that I am financially responsible for any balance due.
I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

SIGNATURE:_____ **DATE:**_____

ONSET DATE:________________________ DIAGNOSIS:________________________