PATIENT INFORMATION FOR MEDICAL RECORDS

S.G. MIKITA PHYSICAL THERAPY

TODAY'S DATE: __________

PATIENT NAME: ____
Last First Middle Initial

ADDRESS: ____
Street City Zip

PHONE: ____________________ DATE OF BIRTH: __________________ AGE: ________

EMAIL ADDRESS: ________________________________

DRIVER'S LICENSE #: __________________ EXP DATE:__________

SOCIAL SECURITY #: ____________________MARITAL STATUS: __________________

IN CASE OF EMERGENCY CONTACT: ______________________________
Name Phone #

TYPE OF INJURY: (please circle) AUTO INDUSTRIAL OTHER

DATE OF INJURY: ____________ HISTORY: (if an accident, how it happened) ______________

____

____

REFERRED BY: ______________________________ PHONE #: ________________

ADDRESS OF PHYSICIAN: ____

DATE LAST SEEN BY PHYSICIAN: ________________

PATIENT EMPLOYER: ____________________________ OCCUPATION: ____________

EMPLOYER ADDRESS: ____
Street City Zip

EMPLOYER PHONE: (____)______________

S.G. Mikita, R.P.T.

PATIENT INFORMATION CONSENT FORM

I have read and fully understand S.G. Mikita, R.P.T.'s Notice of Information Practices. I understand that S.G. Mikita, R.P.T.may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that S.G. Mikita, R.P.T. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in S.G. Mikita, R.P.T.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____

Patient Name

____

Signature

____

Date

S.G. Mikita, R.P.T. A Physical Therapy Corporation
Authorization, Assignment of Benefits and Acknowledgment

I hereby authorize payment by my insurance carrier(s) directly to S.G. Mikita, R.P.T. for medical services rendered and all major medical benefits. I further agree that this document/agreement cann be rescinded and that a rescission will not be honored by my attorney(s) or representatives. I certify that the personal and insurance information contained on the Patient Information Sheet is accurate and correct and that the insurance coverage set forth on such form is in effect as of the date of this form.

I understand and agree that I am financially responsible for all charges regarding the servicing of my health care needs regardless of any insurance claims or coverage. Should the insurance carrier(s) fa to pay any portion of my charges, I understand and agree that I will be responsible for the remaining charges and agree to pay these charges in a timely manner. I do hereby waive and fully give up my right to claim that these charges are not collectible by any reason, or by reason of any applicable statute of limitations or by any applicable bankruptcy filing or defense.

If my account is referred to any attorney for collection or other local action, I agree to pay all reasonable attorney fees and expenses of collection services. I understand and agree that a late charge of 1.5% or $10.00 per month (which ever is greater) will be charged on accounts past due 60 days or more.

I understand and agree that solely as a courtesy to me S.G. Mikita, R.P.T. will bill my insurance carrier(s) for the professional and/or medical expense benefits allowable to me under my current insurance plan/policy and will be accepted by S.G. Mikita, R.P.T. toward payment of the total charge for the professional services rendered to me to reduce the balance of the total charges. I understand and agree that the balance of the total charges due to S.G. Mikita, R.P.T. will be paid from any settlement, judgment, verdict or other payment as specified in the lien agreement of my case(s), and I understand and agree that I will be responsible for the remaining charges and agree to pay the balance of the total charges in a timely manner. The total payments to S.G. Mikita, R.P.T. will not exceed my indebtedness to S.G. Mikita, R.P.T. for services rendered.

I hereby authorize S.G. Mikita, R.P.T. to furnish my insurance company (ies) all information that may be requested to determine my eligibility for benefits pertaining to my illness or injury. I hereby assign all payments to which I am entitled for medical and/or diagnostic expenses incurred by my dependent(s) or myself. I understand that deductibles, co-payments, non-covered items, and charges or expenses determined by Medicare, Medi-cal, or my insurance company (ies) to be "not medically necessary" are my personal financial responsibility. A photocopy of this assignment is as valid as is the original.

I HAVE READ AND UNDERSTAND THE FOREGOING AGREEMENT AND CONSENT.

SIGNED: ______________________________ ***DATE:*** ____________