WEST POINT

PHYSICAL THERAPY CENTER

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ Sex: M / F S.S.#: _____ D.L.#: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone #: _____ Cell #: _____

Employer Name: _____ Phone#: _____

Address: _____ City: _____

State: _____ Zip: _____ Referring M.D.: _____

Accident Related: Y / N Work Related: Y / N Date of Injury: _____

Workers Compensation Insurance: _____

Attorney Name: _____ Phone #: _____

Primary Insurance: _____

Secondary Insurance: _____

Assignment and Release

I, the undersigned, have Insurance Coverage with_____
and assign directly to West Point Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize West Point to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian **Date**

Medicare Authorization

(Medicare Patients Only)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to West Point Physical Therapy for any services furnished me by West Point. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that with my signature, payment may be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the Physical Therapist or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance's and deductibles are based upon the charge determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**