

**NW Sports Physical Therapy, Inc.
NW Hand Therapy**

PATIENT INFORMATION

(Please Print)		
Today's date:	Referring Physician:	Primary Care Physician:

PATIENT INFORMATION

Patient's last name:	First:	MI:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Patient Date of Birth:	Age:	
				/ /		
Parent or Legal Guardian last name:	First:	Patient Marital status:		Sex:		
		Sgl / Mar / Div / Sep / Wid		<input type="checkbox"/> M <input type="checkbox"/> F		
Street address or PO Box:		Patient Social Security no.:	Home phone number:			
			()			
City:		Zip:	Cell phone number:			
			()			
E-mail address:		Would you like to be on our mailing list? <input type="checkbox"/> YES <input type="checkbox"/> NO				

RESPONSIBLE PARTY INFORMATION

Responsible Party Employer:	Responsible Party Occupation:	Employer phone number:
		()
Emergency contact last name:	First: (Spouse or Friend) Circle one	Phone no.:
		()
Chose clinic because/Referred to clinic by (please check one box):		<input type="checkbox"/> Friend or Family:
		Last name: First:
<input type="checkbox"/> Dr. <input type="checkbox"/> Close to home/work <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Newspaper <input type="checkbox"/> Postcard <input type="checkbox"/> Newsletter <input type="checkbox"/> High School <input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Community Seminar <input type="checkbox"/> Other:		

MEDICAL HISTORY

Date of Injury:	Date of Surgery:	How Injury Happened:	Injured Body Part(s):	<input type="checkbox"/> Left <input type="checkbox"/> Right
/ /	/ /			
Accident related? Check which applies:		<input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Home <input type="checkbox"/> Other:		
Are you aware of what your diagnosis is?		<input type="checkbox"/> Yes <input type="checkbox"/> No		

As a courtesy to our other patients and staff members PLEASE turn off your cell phones when arriving at the office. Thank you!

CANCELLATION & NO SHOW POLICY

In an attempt to serve our patients effectively, please attend ALL physical therapy appointments. **Cancelled appointments require 24-hour notice. If you CANCEL without notice or NO SHOW a \$20.00 fee will apply.** Three cancels or no-shows may result in discharging you from our services and IMMEDIATE notification to your referring physician and if applicable, your claims manager.

TREATMENT, SUPPLIES, AND BILLING AUTHORIZATIONS

The information provided by me is true to the best of my knowledge. I authorize Northwest Sports Physical Therapy, Inc. and its affiliate NW Hand Therapy, to treat my dependent or myself. I authorize my insurance benefits be paid directly to the provider of service. I understand that I am financially responsible for any balance remaining for services or supplies rendered if not covered by insurance. Release of my medical information regarding my physical or occupational therapy treatment may be provided to my insurance company for the purpose of processing my medical claim(s). I further assign medical benefits to be paid directly to Northwest Sports Physical Therapy, Inc. for the amount of the account.

Patient/Guardian signature	Date:
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