ELLIS PHYSICAL THERAPY ASSOCIATES
"Setting the standards for personal care"

Patient Information: **Date of Birth: ____/____/____ Sex: M/F**

Name:_____ **Social Security Number:**_____
First Middle Last

Address: _____
Street/P.O Box City State Zip Code

Phone: Home: (_____)_____-_____ **Emergency Contact:** _____

Work: (_____)_____-_____ **Emergency Phone: (_____)_____-_____**

Cell: (_____)_____-_____ **Em. contact relationship:**_____

Email: _____

Employment Status: (circle) Full Time Part Time Retired Unemployed **Occupation:**_____

Employer Name: _____ **Work related injury? Yes / No**

Do you have an attorney representing you in this matter? Yes / No **Motor vehicle accident? Yes / No**

If so, Attorney's Name: _____ **Attorney's phone: (_____)_____-_____**

***Primary Insurance Co.:** _____ **Relationship to insured: Self Spouse Parent**

Primary Subscriber Name: _____ **Date of Birth: ____/____/____ Sex: M/F**

***Secondary Insurance Co.:** _____ **Relationship to insured: Self Spouse Parent**

Secondary Subscriber Name: _____ **Date of Birth: ____/____/____ Sex: M/F**

***Insurance benefits quoted by staff are not a guarantee of coverage. Questions about your benefits should be directed to your insurance company. You must provide your insurance card/cards for accurate billing.**

What are we treating you for today? _____ **Date of onset or injury:** _____

How did this occur? _____ **Referring Physician:** _____

List all medications you are taking: _____

Do you have metal implants? (I.U.D., wires, pins, screws, or artificial joints**) Yes / No**
Do you have other health issues? (heart problems, high blood pressure, stints, pace maker, etc.**) Yes / No**
Explain: _____ **List any drug allergies:** _____

Privacy Authorization
I have received a Notice of Privacy Policy and know that I may obtain a copy of my records at any time at the offices of Ellis Physical Therapy Associates, Inc. and understand a records fee will apply. Yes / No

Please sign: _____ **Date:** _____

Informed Consent
I hereby consent to and authorize Ellis Physical Therapy Associates, Inc. and the therapist in charge of my treatment to perform examinations and treatments which may in his/her opinion be necessary and also understand that treatment outcomes vary and results are not guaranteed.

Please Sign: _____ **Date:** _____

Release of Information
Medical records are confidential and will only be used and disclosed as described in the Notice of Privacy Policy. Please list the individuals authorized to obtain information about you and circle what information they may obtain.

Name of individual: _____ **Info:** Medical **Yes/No** Billing **Yes/No** Insurance **Yes /No**

Name of individual: _____ **Info:** Medical **Yes/No** Billing **Yes/No** Insurance **Yes/No**

Please Sign: _____ **Date:** _____

No Show Fee
I hereby understand that if I cannot make it to my scheduled appointment, I agree to call Ellis Physical Therapy Associates, Inc. prior to my appointment time to re-schedule or cancel the appointment. If I am unable to inform EPTA prior to the scheduled appointment time, a no show fee of $75 applies and is due prior to the next scheduled appointment.

Please Sign: _____ **Date:** _____