PATIENT INFORMATION

(please print)

NAME:_____ **DOB:**_____ / _____ / _____
(Last) (First) (M. Initial)

ADDRESS:_____**SS#**_____ / _____ / _____
(Please give mailing and home address)

_____ / _____
(City) (State) (Zip code) (Phone #)

EMPLOYER:_____ / _____
(Please give name of company if self employed) (Phone #)

_____
(Address)

If you are not the subscriber to your insurance plan or you are a parent or legal guardian to the above patient, please fill out the information below.

Additional Info:_____
(Name) (SS#) (DOB)

_____ / _____
(Employer) (Phone #)

NOTICE TO PATIENTS

All patients are required by New York State law to have a prescription for physical therapy treatment. It is the responsibility of the patient to ensure that our office has any required paperwork or prior authorization for physical therapy treatment, on or before their first visit. Please ask if you are unsure as to what requirements your insurance company may have.

FINANCIAL POLICY

You are responsible for your deductible* and any copayment you have through your insurance. In the event your insurance company fails to pay for services rendered, you may be held responsible.**

AUTHORIZATION FOR DISCLOSURE OF CLINICAL RECORDS

The undersigned hereby authorizes Katonah Physical Therapy, P.C., its officers, directors and employees, to release to my referring physician, my health insurer, or other third party payor making payment for services rendered on my behalf, any information in the custody of Katonah Physical Therapy, P.C. pertaining to the diagnosis, care, and treatment of myself or my son/daughter/ward. This authorization shall remain in effect until revoked by me in writing and delivered to Katonah Physical Therapy, P.C.

"I have read, understand and agree to the provisions of this Patient Notice, Financial Policy, and Authorization for Disclosure of Clinical Records."

Signature:_____ **Date:**_____

***Deductible: the portion of a member's health care expenses that must be paid out-of-pocket before any insurance coverage applies.**
****Copayment: the percentage your insurance company does not pay for, for medical services.**