The Manual Touch Physical Therapy

Patient Information

Welcome! Thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be strictly confidential. (Please Print)

Patient Name_____ DOB:_____ Age:_____

Street Address_____

City_____ State _____Zip _____

Home Phone_____ Cell Phone_____ Fax_____

Email_____

Please circle: Student Single Married Divorced/Separated Widowed

If Child, Parent/Guardian's Name of Financially Responsible:_____

Employer_____ Occupation_____

Employer's address_____ Work Phone_____

Referring Physician:_____ Family Physician:_____
Address: _____Address:_____
_____ _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

Please check of one of the following if it applies:
☐ Worker's Compensation (USA) Insurance Carrier_____
Contact Name & Phone_____Case #_____
☐ Medicare Policy #_____

In case of emergency, please provide us with the name of the nearest relative not residing with you:
Name_____
Phone_____
Relationship_____

I understand that The Manual Touch PT expects prompt payment of all bills for services rendered. I am ultimately responsible for prompt payment for all such charges.

Patient/Guardian Signature_____ Date_____

The Manual Touch Physical Therapy
325 N. Milwaukee Ave. Suite D
Wheeling, IL 60090
o)847-541-7600
f)847-342-7532

Authorization for Release of Records

Patient Name_____

_____ **I have received the notice of privacy rights and responsibilities**.

Please list any insurance companies and/or health care providers that you would like to authorize release of your medical records to upon their request.

RECORDS RELEASE TO INSURANCE

I authorize The Manual Touch Physical Therapy to release pertinent clinical and account information to the following insurance companies to facilitate my reimbursement:

1._____

2._____

3._____

RECORDS RELEASE TO HEALTHCARE PROVIDERS

I authorize The Manual Touch Physical Therapy to release pertinent clinical and account information to the following practitioners:

1._____

2._____

3._____

VIDEO/PHOTOGRAPH CONSENT

I understand that the medical professionals at this facility may be taking pictures/videos progress for several purposes:

Marketing Purposes
Documentation of Functional Deficit
Research and Education Purposes

I understand that use of my case for any research will be done with facial & identifying features blocked out/concealed and that at any time I may revoke further photographic/video consent. I understand that before research concerning my case is submitted, I will be notified and allowed to review this data for approval. Photos used for marketing purposes may reveal your face unless specified not to.

Patient or Guardian Signature_____Date_____

Witness Signature_____Date_____

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