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/Seperated 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/Medicaid (USA) 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____

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:

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.

Patient or Guardian Signature________________________________Date_______________

Witness Signature________________________________Date_______________

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