



**Harmony
Hand &**

Physical Therapy Center, Inc.

First Appointment _____

What are we treating? _____

Therapist: _____ Prescription Date: _____

PATIENT INFORMATION

Name _____ Referring Physician _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birth Date _____ Social Security # _____ Sex: Female _____ Male _____

How did you hear of us? MD _____ Friend/Family _____ Internet _____ Ad _____ Self _____ Other _____

Employer/School _____ Married _____ Single _____ Divorced _____

Date Symptoms Started/Date of Injury _____ Date of Surgery _____

Person to contact in case of emergency _____ Phone _____

INSURANCE INFORMATION

Insurance Company _____ Workers Comp claim # _____

Guarantor Name _____ Relationship to patient _____

Phone # _____ Address (if different) _____

Guarantor Birth Date _____ SS# _____

MEDICAL HISTORY

Family Physician _____ Do you want a report sent to your Family Physician? YES NO

Any serious illnesses or operations? Yes No If yes, describe _____

Are you pregnant? Yes No Cancer History? _____

List medications you are currently taking and the correlating diagnosis: _____

List of Allergies: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the above information is complete and correct. I certify that I, and/or my dependent(s), assign directly to HARMONY HAND & PHYSICAL THERAPY CENTER, INC. all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance including any finance charges incurred for late payments. I authorize the use of my signature on all insurance submissions. Harmony Hand & Physical Therapy Center, Inc. may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. We do NOT bill secondary insurance claims; however, we will give you the necessary information to assist you in billing your secondary insurance. Privacy Practices-We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone. Signature below is acknowledgement that you have received a Notice of our Privacy Practices. All copays will be due prior to each visit. Our cancellation policy requires a 24 hour notice when it is necessary to cancel an appointment, otherwise, we reserve the right to charge \$25 for missed appointments. This consent will end one year from the date of your last appointment.

Signature (Patient or Parent if Minor) _____ Date _____

Witness _____ Date _____

OFFICE USE ONLY

ICD-9 Codes _____; _____; _____ Splint _____ Rt/Lt body _____