McCarthy Physical Therapy and Sports Medicine, Inc.
Patient Information

Name: _____Account#_____
Address_____State: _____Zip:_____
Home Phone:_____ Work Phone:_____
Emergency Contact (relationship?): _____Phone:_____
Birth date :_____Age:_____ SSN: _____ - _____ - _____Sex M F
Employer:_____
Address:_____
City:_____ State: _____Zip:_____

INSURANCE INFORMATION

Guarantor name and relationship:_____Birth date:_____
Insurance Name: _____Phone:_____
Address: _____
City: _____State:_____ Zip:_____

SECONDARY INSURANCE

Guarantor Name:_____ Guarantor DOB_____
Insurance Name: _____ Phone:_____
Address: _____City: _____State: _____Zip:_____

Injury at Work? Yes No Date of Injury: _____Motor Vehicle Accident? Yes No
Employer at time of injury: _____
Referring Doctor:_____
Diagnosis/Body Part:_____

AUTHORIZATION AND ASSIGNMENT

I, the undersigned, do hereby agree and give my consent for McCarthy Physical Therapy and Sports Medicine, Inc., to furnish physical therapy evaluation and treatment considered necessary and proper in diagnosing or treating the physical condition.

I hereby assign all physical therapy benefits to McCarthy Physical Therapy and Sports Medicine, Inc. I understand that I am financially responsible for all charges. Cancellations or missed appointments with less than 24 hours advance notice to our office are subject to a $25.00 fee. I hereby authorize release of all clinical and payment information necessary to secure payment. A photocopy shall be considered valid.

Signature:_____Date:_____

Print: _____Date:_____