Cambridge
Physical Therapy Center

Patient Information Verified DL: ☐ Yes ☐ No

Last Name: First Name: Middle Initial:

Address: City: State: Zip Code:

Home Phone: Cell Phone: Email Address:

Date of Birth: _____ SSN#: _____ Sex: ☐ M ☐ F Marital Status: _____

Cambridge Physical Therapy Inc. may contact me by (please mark all that apply) ☐ Home Phone ☐ Cell phone ☐ Text ☐ Email

Employer Information

Employer Name: Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student

Employer Phone:

Secondary Contact Information

Contact Name: Phone Number: Relationship to Patient:

Physician Information

Name of Referring Physician: _____ Telephone #: _____

Family Physician: _____ Telephone #: _____

Additional Questions

Auto Related: ☐ Yes ☐ No Work Related: ☐ Yes ☐ No Accident Related: ☐ Yes ☐ No Body Part/Diagnosis: Date of Injury:

Have you received PT, OT, Speech therapy services since January 1 of this year? ☐ Yes ☐ No

Do you have (mark all that apply) ☐ High BP ☐ Diabetes ☐ Seizures ☐ Asthma Other: _____

Allergies to medications or others (please list):

_____

MEDICARE ONLY – Additional Questions

Have you, or are you receiving Home Health Services? ☐ Yes ☐ No If yes, Last Date of Service? _____

If Yes, Name of Home Health Agency: _____ Phone: _____

Have you received PT, OT or Speech therapy services since January 1 of this year? ☐ Yes ☐ No

Patient Signature: _____ Date: _____

Insurance Information

POLICY HOLDER INFORMATION, OR GUARDIAN OF A MINOR INFORMATION:

Last Name: First Name: MI: SSN: DOB:

Patient Relationship to Policy Holder or Guardian:

Address: (If same as patient, check here ___) City State Zip

Employer Name: Employer Phone:

Primary Insurance Section	**Secondary Insurance Section**
Payer / Plan	Payer / Plan
Policy / ID#:	Policy / ID#:
Group #:	Group #:

I consent to Cambridge Physical Therapy, Inc., for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Cambridge Physical Therapy, Inc., to exchange with and/or release requested and/or necessary information on my medical care to my physician(s), insurance carrier(s), and to any other persons or entities **EXCEPT** those which I have listed below. If none, please check here ____ and leave the following line blank.

I have read and understand Cambridge Physical Therapy, Inc. Privacy Notice. I further understand that I may obtain a copy of this policy notice upon my request.

Signature **Date**

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to Cambridge Physical Therapy, Inc. I understand that I am financially responsible for payment of applicable costs regardless of insurance coverage. I also agree by signing below, in order for Cambridge Physical Therapy, Inc. to service my account or to collect any amounts I may owe, Cambridge Physical Therapy, Inc., or any collections service used, may contact me by telephone at any telephone number associated with my account, including wireless numbers, which could result in charges to me. Cambridge Physical Therapy, Inc., or any collections service used, may also contact me by sending text messages or emails, using any email address I provide. Methods of contact may include using pre-recorded or artificial voice messages, and/or use of an automatic dialing device, as applicable.

Signature **Date**

Responsible Party's Signature (if patient is a minor) **Relationship to patient** **Date**