YORK PHYSICAL THERAPY
2835 NORTH NEBRASKA AVE.
YORK, NEBRASKA 68467

DATE:___________________________

NAME:____ **DATE OF BIRTH:**______________ **AGE:**________
(FIRST) (M.I.) (LAST)

MAILING ADDRESS:______________________________**CITY:**____________________**STATE:**_____ **ZIP:**__________

HOME PHONE:(______**)**_________________ **CELLULAR PHONE:(**______**)**_________________

GENDER: M OR F **MARITAL STATUS:** S M W D **SS #:**__________________________________

EMPLOYER:_______________________________________ **ADDRESS:**_______________________________________

EMPLOYER PHONE:(_____**)**_______________________

SPOUSE'S NAME:__________________________________ **SPOUSE'S EMPLOYER:**___________________________

EMERGENCY CONTACT (OTHER THAN SPOUSE)**:**____
(NAME)

EMERGENCY PHONE:(_____**)**_________________

IS TODAY'S VISIT DUE TO WORKMAN'S COMPENSATION? YES OR NO

IS TODAY'S VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES OR NO

REFERRING PHYSICIAN:____

IF YOU ARE A MINOR OR COLLEGE STUDENT:
PARENTS NAME:____ **ADDRESS:**__________________________________

CITY:__________________________ **STATE:**_________ **HOME PHONE(**_____**)**_______________

PARENTS EMPLOYER'S:(FATHER)_________________________________ **PHONE:(**_____**)**______________

(MOTHER) __________________________________ **PHONE:(**_____**)**______________

CONSENT FOR TREATMENT / ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I understand that I have been referred to York Physical Therapy, Inc. and authorize York Physical Therapy, Inc. to provide rehabilitative services as per my referral and/or as developed, modified and progressed at the direction of York Physical Therapy, Inc. clinicians and/or my physician. I also assign directly to York Physical Therapy Inc. all medical benefits payable by my insurance company or Medicaid or Medicare benefits. I authorize release of any records necessary to secure payment of benefits to my insurance company or Medicare or Medicaid.

MEDICARE PATIENTS ONLY: CERTIFICATION AND FINANCIAL AGREEMENT – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed for this or a related Medicare claim. I request that the payment for authorized benefits be made directly to York Physical Therapy on my behalf. I understand that I am responsible for any medical insurance deductible and co-insurance, and for the cost difference of any private accommodation in which I am placed at my own request.

SIGNATURE:____ **DATE:**________________________

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ONSET DATE:__________________________________ DIAGNOSIS:____