

**Sulphur Springs Physical Therapy
1129 E. Industrial
Sulphur Springs, Texas 75482**

Phone: 903-885-9906

Fax: 903-438-9636

DATE: _____ **TREATING THERAPIST:** _____

NAME: (Last,First,MI) _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell:** _____ **E-Mail:** _____

Marital Status: Married / Single / Widowed **Sex:** Male Female

Date of Birth: _____ **Doctor:** _____ **SS#:** _____

Emergency Contact Person: _____ **Phone#:** _____

Employer: _____ **City:** _____ **State:** _____ **Zip Code:** _____

DATE OF INJURY: _____ **Workmens Compensation- If at any time this is not deemed work related you would be responsible for the bills on this claim. _____ (Initials)**

INSURANCE INFORMATION:

Person responsible for bills: _____ **Phone#:** _____

Mailing Address: _____

Name of Insurance: _____

Primary Ins: _____

Secondary Ins: _____

HOW DID YOU CHOOSE OUR CLINIC?

1) Your Doctor 2) Website 3) Phone Book 4) Friend 5) Other _____

Are you presently receiving Home Health Services: Yes No (Circle One)

HIPPA Privacy Act

I have received information regarding Notice of Privacy Practices at Sulphur Springs Physical Therapy. _____ (Initials)

Authorization of Treatment

I hereby request and authorize treatment from Sulphur Springs Physical Therapy and associates or assistants of their choice. _____ (Initials)

I understand that I am responsible for the payment of all services rendered by Sulphur Springs Physical Therapy. Any Charges not covered by insurance remains my responsibility to pay. I authorize the release of my medical records solely for insurance and billing purposes. In order to have us bill your insurance, you must sign this release. I authorize payment of my medical benefits to Sulphur Springs Physical Therapy.

Signature: _____ **Date:** _____