



Seneca Physical Therapy Patient Information Form (Please Print)



Date: _____ Date of Injury / Onset: _____

*Patient Name: _____ Date of Surgery: _____

Maiden Name: _____ Fax#: _____

Patient Address: _____ Email Address: _____

City _____ State _____ Zip _____ Why did you choose Seneca PT? (circle one below)

Birth Date: _____ *Dr. told me about Seneca* *Dr's staff recommended*

S.S.#: _____ *I'm a returning patient* *Friend / Family*

Phone(H) _____ (W) _____ *Website* *Advertisement*

Phone(C) _____ *Other:* _____

Marital Status: Married Single Widowed Divorced Referring Physician: _____

Sex: Male Female Primary Care Physician: _____

Patient's Occupation: _____ Emergency Contact: _____

Patient's Employer: _____ Contact's Phone Number: _____

***If the patient is not the primary subscriber on insurance account, please fill out next 3 lines**

Insured's Name: _____ Insured's DOB: _____

Insured's Employer: _____ Insured's SSN: _____

Insured's Employer Address: _____

Have you had physical therapy in the past for this problem?

Yes No

A. Is this a Worker's Compensation Case?	Yes	No	
If yes, has this claim been accepted?	Yes	No	Pending

B. In this a motor vehicle related injury?	Yes	No	
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If you answered YES to A or B above, please provide the following information

Insurance Co. Name & Address: _____

Claim# _____ Adjustor's Name: _____ Ph.# _____

Attorney Name: _____ Ph.# _____

Address: _____

I CERTIFY that the information I have given above is correct and I authorize the release of any necessary information to my insurance company. I permit a copy of this authorization to be used in place of the original and I authorize this signature to be used when processing claims. I may revoke this in writing at any time.

I HEREBY assign Seneca Physical Therapy, Inc. all payments rendered for my dependent or myself. If my current policy prohibits direct payment to Seneca Physical Therapy, I hereby instruct and direct my insurance company to make the check payable to Physical Seneca Therapy. In the event my bill becomes delinquent (over 90 days past due), I understand and agree that I am responsible for paying all charges including co-payments and coinsurance PLUS finance charges in the amount of 1.5% per month on the unpaid balance, balance, reasonable collection fees and/or attorney fees and court costs. In addition, I authorize Seneca Physical Therapy, Inc. to initiate a complaint to the insurance commission for any reason on my behalf.

Signature: _____ Date: _____