OSR PHYSICAL THERAPY

Patient Demographic Form

Patient Information

Name (Last, First, MI)	Date of Birth	Age	Sex ____Male ____Female
Address	City, State, Zip		
Primary Phone Number __Home __Work __Cell	Alternate Phone Number __Home __Work __Cell		
Employer/School	Occupation	Email Address	

Emergency Contact

Name	Relationship	Phone Number

Person Responsible for Bill (If under 18 years old)

Name	Date of Birth	
Relationship to Patient	Primary Phone Number	Alternate Phone Number
Address	City-State-Zip Code	

Communication Release

At which number, if any, may we leave messages for you? __Home __Work __Cell __None
Would you like to receive text messaging or email reminders about upcoming appointments? __Text(Std. rates may apply) __Email __None

Referral Source

How did you hear about OSR? Doctor_____ Family/Friend_____ Website___
Drive By_____ Insurance Referral___ Other_____

****Treatment Authorization:** I hereby authorize Orthopedic & Sport Rehabilitation, LLC or their designee(s), to treat my or the patient's condition as they deem appropriate.

****Assignment of Benefits:** I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to OSR for any services rendered to me by or on my behalf of OSR.

****Medicare Patients:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Orthopedic & Sport, LLC for any services furnished to me by the organization. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

****Records Release to Insurance Carrier(s) and Other Payers**: I hereby authorize OSR to release to my insurance company, health plan, HMO, no fault carrier, and/or worker's compensation carrier, any information including my complete health record needed to determine for services provided by or on behalf of OSR.

****I understand that I am financially responsible for charges not covered under my insurance policy**. All benefits are subject o medical necessity and are paid according to the terms of your policy. If your deductible has not been met, you will be responsible for that portion in addition to any other co-insurance and/or co-pays.

For all the above information: _____

Signature (Parent/Guardian if patient is under 18 years old) Date