Brunswick Physical Therapy
70 Souder Road
Brunswick, MD 21716

****Please print in black ink****

Patient Information

Last Name: ______________________ First Name: _____________________ MI: _____

Nickname: ____

Physical Address: ____

City/State: _______________________________________ Zip: ____________________

Mailing Address: ☐ SAME AS ABOVE

Address: ____

City/State: _______________________________________ Zip: ____________________

Home Phone: _________________ Work: _______________ Cell: _________________

Can we leave appointment information on your voicemail? Yes _______ No ________

DOB: ________ Age: _______ SSN: ______-_____-_______ Gender: Male Female

Marital Status: Married Single Are you a student: Yes No

Email: ____

Would you like to receive appointment reminders via email? Yes ________ No ________

Employer Name: ____

Responsible Party (minors only):____

Emergency Contact Name: ____

Relation to you: ___________________________ Phone: ____________________

Area to be treated: _______________ Left Right Surgery/Injury Date: ______________

Is this injury from an auto accident ___________ Is this a work related injury ____________

If so, date of accident _________________ State accident happened _________________

Attorney Name & Phone (if applicable): _______________________________________

Primary Care Physician: ____

Referring Dr.: ____

How did you hear about us: ____

INSURANCE FILING AND TREATMENT RELEASE

Assignment of insurance, benefits, release of information and authorization to treat; and the responsibility for payment, assignment of benefits authorization and medical release: I, the undersigned, do hereby expressly guarantee payment in full of any and all claims and charges in consideration for medical services rendered to, or to be rendered to me by Brunswick Physical Therapy. I hereby authorize and demand the assignment of my basic medical, major medical, auto medical, third party medical or any other medical benefits that may apply, herein specified and otherwise payable to me, directly to Brunswick Physical Therapy, LLC. I authorize Brunswick Physical Therapy to release medical information acquired in the course of my treatment and examination to my insurance company. If for any reason the account should become delinquent, I agree to pay all rebilling charges, interest charges, collection of costs and reasonable legal fees. I understand and agree to the Brunswick Physical Therapy payment policies.

Signature: ____ Date: ___________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgment****

I understand a copy of this office's Notice of Privacy Practices is available to me upon request.

Extended Authorization Option:
Please list any person you would like to authorize to have access to your billing, make/change or access to your appointment or health information (with the exclusion of information that is protected under State or Federal law) such as **your spouse, caretaker, parent or other family member**. If their name is not listed below no information will be given or changed, including appointments. If you wish not to list anyone, write "N/A".

Name Relationship

____

____

____

Signature **Date**

____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)