Edge Physical Therapy 11336 S. 96th St , Ste 114, Papillion, NE 68046 (402)315.3603 **Date**_____

PATIENT INFORMATION:

Treatment Area_____

PATIENT NAME _____ DATE OF BIRTH _____
First Middle Initial Last

SS# _____ AGE _____ SEX _____ REFERRING PHYSICIAN _____

HOME ADDRESS _____
Street Address City State Zip

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS_____ SCHOOL IF STUDENT_____

EMPLOYER _____
Name Street Address City State Zip Phone #

EMERGENCY CONTACT _____
Name Phone # Relationship

GUARANTOR INFORMATION (Person Responsible for Bill)

Work Comp Injury Yes/No Auto Accident Yes/NO Sports Injury Yes/NO

GUARANTOR NAME _____ DATE OF BIRTH _____

SS# _____ RELATIONSHIP TO PATIENT _____ SEX _____ MARITAL STATUS _____

HOME ADDRESS _____
Street Address City State Zip

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____
Name Street Address City State Zip Phone #

PRIMARY INSURANCE INFORMATION

INS. COMPANY NAME _____ _____ GROUP # _____ POLICY # _____

INS. COMPANY ADDRESS _____
Street Address City State Zip

SECONDARY INSURANCE INFORMATION

INS. COMPANY NAME_____ GROUP#_____ POLICY # _____

INS. COMPANY ADDRESS_____
Street Address City State Zip

Insurance verification (office use only)

Verified with_____ _____/date_____. Visit limits/year_____Deductible/Year_____ Amt Met_____Ins %_____
Authorization #_____

A . Notice of Privacy Practices. The policies and procedures of Edge Physical Therapy are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Privacy Notice of Edge Physical Therapy has been made available to me.

B. **Authorization to Treat**. I authorize and direct the medical practitioners of Edge Physical Therapy and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate. I understand that I have the right to receive information, to request treatment, and to seek a second opinion. Patients 18 years and younger must be accompanied by guardian

C. **Assignment of Insurance Benefits.** I hereby assign all medical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Edge Physical Therapy. I understand that I am financially responsible for co-payments, co-insurance, deductibles, and any other balance not paid for by my insurance plan.

The undersigned patient or patient's guardian hereby acknowledges to have read, understood and agreed to conditions set forth in the Notice of Privacy Practices, Authorization to Treat, Assignment of Insurance Benefits, and, if applicable, Medicare Patient's Information.

_____ _____
Signature of Patient or Legal Guardian (Employee Initials if consent written and sent with minor patient or obtained verbally) Date

_____
Printed name of Patient