PATIENT INFORMATION / PERMISSION TO TREAT

Today's Date_____ Date of Injury/Onset of Problem_____

Patient Name_____ Date of Birth_____

Social Security #_____Male_____Female_____

Mailing Address_____

City, State, Zip_____

Phone/Home_____Work_____

Have you been a patient at Hand To Shoulder Therapy before? ___Yes ___No

Referring Physician_____Phone_____

In case of emergency, notify_____

Method of Payment_____

If insurance, name of insurance company_____

Policy holder_____Relationship_____

Policy number_____Group number_____

Address of insurance company_____

Phone number of insurance company_____

I, _____, authorize Hand to Shoulder Therapy to release any information regarding my medical history, symptoms, and treatment to third party payers. A photocopy of this authorization shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this authorization. (If minor, signature of parent or legal guardian is required.) At this time I consent to occupational therapy treatment performed at Hand To Shoulder Therapy. In addition, I authorize payment of medical benefits to Hand to Shoulder Therapy, the supplier of services described above.

X_____Date_____