KEE PHYSICAL THERAPY

Date: _____
Acct#: _____

Patient Information: **Do you have Zero Card?: ___ YES ____ NO**

Name_____ SSN_____ DOB_____

Address_____ City_____ Zip_____

Home Phone _____ Cell Phone_____

Place of Employment_____ Work Phone_____

Email Address_____

Sex: Male_____ Female_____ Marital Status: Single_____ Married_____Widowed_____

Spouse Information:

Name_____ Cell Phone_____

Place of Employment_____ Work Phone_____

Name of Insured_____ Insured's DOB_____

Emergency Contact_____ Relationship_____ Phone _____

Doctor referring you to therapy_____ Date of next visit _____

<u>If Minor (If not a Minor, please skip to next page):</u>

Mother's Name_____

Address (if different from patient)_____ City_____ Zip_____

Home Phone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

Father's Name_____

Address (if different from patient)_____ City_____ Zip_____

Home Phone_____ Cell Phone_____

Place of Employment_____ Work Phone_____

*****OVER*****

Eric Smith PT, MPT
6705 E 81st St. Suite 170 Tulsa, OK 74133 | Phone 918-710-5790 | Fax 918-728-2217

KEE PHYSICAL THERAPY

Date of Injury_____ Did this injury occur at: Work_____ Auto_____ Home_____ Other_____

Details of injury/condition _____

_____

Are you receiving home health services at this time? Yes _____ No _____

Home Health Agency _____ Phone_____

Do you wear a pacemaker? Y____ N____ Do you have diabetes? Y_____ N_____ Are you pregnant? Y_____ N_____

Any other pertinent health information? _____

If work related injury:

Employer at the time of injury _____ Phone_____

Address _____City_____State _____ ZIP _____

Supervisor and/or contact person_____Phone_____

Do you have an attorney? Y_____ N_____

Attorney Name_____ Phone_____

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I hereby give my consent for treatment and/or evaluation by Eric C Smith LLC dba KEE Physical Therapy. I authorize payment of benefits be made directly to Eric C Smith LLC dba KEE Physical Therapy. In consideration for services rendered on this date and all subsequent dates of services, I guarantee payment for any and all services that my insurance indicates as my responsibility, including collection costs, and reasonable attorney fees. I understand that if my account carries a balance over 30 days, I will be charged 1.5% of the monthly balance. I understand that the patient responsibility portion of charges are due at the time of service.

Responsible Party Signature_____ Date _____

I acknowledge that I am aware of and have received the Notice of Privacy Practices as it pertains to my personal health information.

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I hereby authorize the release of information to the referring physician and any entity responsible for the payment or authorization of payment on my account. This information may include evaluations, diagnostic reports, treatment documentation, prognosis, recommendations and other data pertaining to my treatment for this condition/injury. I understand that this information may be conveyed by telephone, in writing, by facsimile or electronic transmission.

Responsible Party Signature_____ Date _____

Eric Smith PT, MPT

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