HAVELOCK PHYSICAL THERAPY
6319 HAVELOCK AVENUE
LINCOLN, NE 68507-1328

DATE:_____

NAME:_____DATE OF BIRTH:_____ AGE_____
(FIRST) (M.I.) (LAST)

MAILING ADDRESS:_____CITY:_____STATE:_____ ZIP:_____

HOME PHONE:(_____)_____ CELLULAR PHONE:(_____)_____

GENDER: M OR F **MARITAL STATUS:** S M W D **SS #_____**

EMPLOYER:_____

ADDRESS:_____ EMPLOYER PHONE:(_____)_____

SPOUSE'S NAME:_____

SPOUSE'S EMPLOYER:_____

EMERGENCY CONTACT (OTHER THAN SPOUSE)**:_____**
(NAME)

EMERGENCY PHONE: (_____)_____

IS TODAY'S VISIT DUE TO WORKMAN'S COMPENSATION? YES OR NO

IS TODAY'S VISIT DUE TO A MOTOR VEHICLE ACCIDENT? YES OR NO

REFERRING PHYSICIAN: _____

IF YOU ARE A MINOR OR COLLEGE STUDENT:
PARENTS NAME: _____
ADDRESS: _____

CITY:_____ STATE:_____ HOME PHONE(_____)_____

PARENTS EMPLOYER'S:(FATHER)**_____ PHONE:(_____)_____**

(MOTHER) **_____ PHONE:(_____)_____**

CONSENT FOR TREATMENT / ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I understand that I have been referred to Havelock Physical Therapy, Inc. and authorize Havelock Physical Therapy, Inc. to provide rehabilitative services as per my referral and/or as developed, modified and progressed at the direction of Havelock Physical Therapy, Inc. clinicians and/or my physician. I also assign directly to Havelock Physical Therapy Inc. all medical benefits payable by my insurance company or Medicaid or Medicare benefits. I authorize release of any records necessary to secure payment of benefits to my insurance company or Medicare or Medicaid.

MEDICARE PATIENTS ONLY: CERTIFICATION AND FINANCIAL AGREEMENT – I certify that the information given by me in applying for payment under TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration (Medicare) and its agents any information needed for this or a related Medicare claim. I request that the payment for authorized benefits be made directly to Havelock Physical Therapy on my behalf. I understand that I am responsible for any medical insurance deductible and co-insurance, and for the cost difference of any private accommodation in which I am placed at my own request.

SIGNATURE: ____
DATE: _________________________

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

ONSET DATE:__________________________________
DIAGNOSIS:____