

Office Use MT MS *Med* *FFS*

Patient name: LAST FIRST MIDDLE INITIAL	Date of Birth MM/DD/YY:	Patient SSN #:
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Address:	City & State:	Zip Code:
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Gender: Male Female Marital Status: Single Married Divorced Widow

How can we contact you? Please provide the numbers you authorize us to call and circle the your primary contact preference

Cell Phone:	Home Phone:	Work Phone:	Email Address:
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Referring Doctor: Last First Middle Initial	Shall we send a report? Yes No
<i>(Yes for all Medicare patients)</i>	

Primary Care Physician: Last First Middle Initial	Shall we send a report? Yes No
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Emergency Contact: Last First Middle Initial	Emergency Contact relationship to you:
Emergency Contact Phone:	

What problem are we seeing you for?

What influenced you to choose our service?	Is this your first time to physical therapy?
Did someone specifically recommend our service? If so, who was it and may we thank them with a card of appreciation? Yes No	Yes No

Please initial all three boxes. Your signature below confirms receipt and understanding of the information provided.

- I have received a copy of the **Dynamic Systems Rehabilitation, PLLC Financial & Fee information** and understand its content.
 - I have been given the opportunity to read the **Dynamic Systems Rehabilitation, PLLC Privacy Notice** and know I may request a personal copy.
 - I authorize **Dynamic Systems Rehabilitation, PLLC** to render physical therapy to myself/my child or person to whom I am legal guardian.
 - I understand that if I become Medicare eligible during treatment, I am responsible for all service charges until I furnish my Medicare information.
- Medicare patients only: Please also initial the following three boxes:**
- I authorize **Dynamic Systems Rehabilitation, PLLC** to furnish my insurance company with requested information relating to my illness or injury.
 - I authorize payment to be made to **Dynamic Systems Rehabilitation, PLLC**.
 - I understand that **Dynamic Systems Rehabilitation, PLLC** does not participate in any Medicare Advantage programs or as a secondary insurance.

Signature: _____ Today's Date: _____

This section applies to Medicare patients only.

WE WILL NEED A COPY OF YOUR MEDICARE INSURANCE CARD TO CORRECTLY FILE YOUR CLAIM

If you are a Medicare patient please answer the following question by putting an "x" or "✓" in the box.

Have you had other Physical Therapy in this calendar year? Yes No If "Yes", how many visits?

Do you have a secondary insurance coverage supplement to Medicare? Yes No

If yes, who is your secondary insurer?