

| <b>Dynamic Systems Rehabilitation, PLLC</b>  |   |                        |  | <b>Patient Information</b>     |                       |
|--|---|------------------------|--|--------------------------------|-----------------------|
| MJT  | EF  | KD                     | PG                                     |                                |                       |
| Referring doctor:  |   |                        |  | Patient Sex: M F               |                       |
| Primary Care Physician:  |   |                        | Shall we send him/her a report?<br>Y N |                                |                       |
| Patient name: LAST   |   | FIRST                  | MIDDLE INITIAL                         | Birthdate                      | Patient SS #          |
| Address:   |   |                        | City, State                            |                                | Zip                   |
| Home telephone:  |   | Work telephone:        |  | May we call you at work? Y N   |                       |
| Employer \ School:   |   | Email Address:         |  |                                | Marital Status: M S W |
| <input type="checkbox"/> Emergency contact   | Phone #:  |                        |  | Spouse \ Parent date of birth: |                       |
| <input type="checkbox"/> Spouse \ Parent name:   |   |                        |  |                                |                       |
| Spouse \ Parent Employer Name & Address:   |   |                        |  |                                |                       |
| What problem are we seeing you for? Right \ Left   |   |                        |  |                                |                       |
| How did you choose our service? _____  |   |                        |  |                                |                       |
| <b><i>WE WILL NEED A COPY OF YOUR MEDICARE INSURANCE CARD TO CORRECTLY FILE YOUR CLAIM</i></b>                           |   |                        |  |                                |                       |
| Policy Holder /Insured Name:   |   | Insured date of birth: |  | Insured SS #:                  |                       |
| Employer:  |   |                        |  |                                |                       |
| Primary Insurance Company to bill:   |   |                        |  |                                |                       |
| Insurance Company Address:   |   |                        |  |                                |                       |
| Group # \ Claim #:   |   |                        | Agent or Contact:                      |                                |                       |
| <b>Secondary Insurance</b>   |   |                        |  |                                |                       |
| Policy Holder / Insured Name:  |   | Insured date of birth: |  | Insured SS #:                  |                       |
|  |   |                        |  | Relationship to Patient:       |                       |
| Secondary Insurance Company:   |   |                        | Group # \ Claim #                      |                                |                       |
| Address:   |   |                        |  |                                |                       |
| Please initial appropriate boxes. Your signature below confirms receipt of and understanding of the information provided |   |                        |  |                                |                       |
| <input type="checkbox"/>   | I authorize <b>Dynamic Systems Rehabilitation, PLLC</b> to furnish my insurance company with requested information relating to my illness or injury |                        |  |                                |                       |
| <input type="checkbox"/>   | I authorize payment to be made to <b>Dynamic Systems Rehabilitation, PLLC</b> .   |                        |  |                                |                       |
| <input type="checkbox"/>   | I have received a copy of the <b>Dynamic Systems Rehabilitation, PLLC Financial &amp; Fee information</b> and understand its content                |                        |  |                                |                       |
| <input type="checkbox"/>   | I have been given the opportunity to read the <b>Dynamic Systems Rehabilitation, PLLC Privacy Notice</b> and know I may request a personal copy     |                        |  |                                |                       |
| <input type="checkbox"/>   | I authorize <b>Dynamic Systems Rehabilitation, PLLC</b> to render physical therapy to myself/my child or person to whom I am legal guardian         |                        |  |                                |                       |
| Signature  |   |                        |  | Today's Date                   |                       |