Ascend Physical Therapy
119 Grove St.
Montclair, NJ 07042
Phone 973-744-3561
Fax 973-744-2838

Patient Information
Please PRINT CLEARLY

Name: Last:_______________________First:______________________ Name you prefer: ______________
Street Address:____
City:___________________________________State:_______________ Zip Code:________________________
Home Phone: ____________________ Work Phone:_____________________ Cell:______________________
Date of Birth:_______________Social Security # (For Insurance Verification Purposes)___________________
Email:____
How did you hear about us? ____
Employer:____ Job title:________________________________
Employer Address:____
Name of Spouse/ If Child, Parent Name:____
Emergency Contact:____Phone:____________________

Reason for visit/ Date Symptoms began: ____
Referring/Prescribing Physician:____

Is this related to an auto accident? ____ Yes ____ No If yes date of accident: ______________
Is this related to a worker's comp.? ____ Yes ____ No If yes date of accident: ______________

Primary: Health Insurance Company: ___________________________________ ID: ________________________
Subscriber's Name: ____________________________ Subscriber's Date of Birth: ______________________
Relationship to Subscriber: __________________ Subscriber's Address & Phone if different from patient:
Address: ____ Phone: ___________________

Secondary: Health Insurance Company: ___________________________________ ID: _____________________
Subscriber's Name: ____________________________ Subscriber's Date of Birth: ______________________
Relationship to Subscriber: __________________ Subscriber's Address & Phone if different from patient:
Address: ____ Phone: ___________________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: **Ascend Physical Therapy** for professional/medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee and I agree to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment as required by my insurance policy. I understand that ***Ascend Physical Therapy*** is compliant with HIPAA and will protect my *Protected Health Information* (**PHI**) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. *I also authorize the release of any information pertinent to my case to any insurance, adjuster or attorney for the purpose of securing payment under this insurance policy or to any medical provider associated with my case to effectively treat me, following HIPAA guidelines.* The authorization is in effect until 90 days from the date the last bill is collected.

Patient Name: ____ Patient Signature: ____
Parent Name (If patient under 18): ___________________________________ Parent Signature: ___________________________________
Date: _________________________ Witness Signature: ______________________________________

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CONSENT TO TREAT

I, hereby, authorize Ascend Physical Therapy and/or all licensed personnel to perform or have performed upon me, the above named patient, appropriate assessment and treatment procedures.

Signature:____ Date:____________________
Signature of Parent if Patient is a minor:____
Parent Name:____

Authorization to Release Healthcare Information

To: ____
Doctor/Physician/Attorney/Facility Names

If MVA or Workers' Compensation Case:

Case Manager Name: _____________________________________ Phone Number: _____________________
Claim #: ______________________________________ Date of Accident: ______________________________

I am currently being treated at Ascend Physical therapy and authorize the release of any medical reports including but not limited to: MRI`s, Evaluations, Progress Notes, Examination Forms, etc. to this office.

Ascend Physical Therapy
119 Grove Street, Montclair, NJ 07042
Phone: 973-774-3561
Fax: 973-744-2838

Patient Name: _______________________________ Patient Signature: __________________________________
Parent Name (If patient under 18): __________________________ Parent Signature: ________________________
Date: ___________________ Witness Signature: ____