KAUFMANN
PHYSICAL THERAPY
& ASSOCIATES

## PATIENT BACKGROUND INFORMATION

Name_____ Date_____

Social Security Number_____ Birth Date_____ Age _____

Address_____

City_____State____ Zip_____ DL#_____

Home Phone_____ Work_____ Cell_____

Email Address_____ Referred By _____

Employer_____ Occupation_____

Person To Call In Case Of Emergency_____ Phone_____

**PLEASE PROVIDE A COPY OF YOUR DRIVERS LICENSE AND INSURANCE CARD UPON INITIAL EVALUATION.**

Is condition related to an auto accident? YES NO
Is condition related to a job accident? YES NO
Is an attorney involved? YES NO Attorney's Phone _____

**IF PATIENT IS A MINOR, PLEASE GIVE NAME AND ADDRESS OF PERSON LEGALLY RESPONSIBLE.**

Name_____ Phone_____
Address_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Kaufmann Physical Therapy to release any information acquired in the course of evaluation or treatment of the patient to any person or entity, which is or may be liable for all or any portion of Kaufmann Physical Therapy's charges. A photocopy of this form shall be deemed as valid as the original.

Signature_____ Date_____
Patient/Parent/Guardian

I am fully aware of the three page HIPPA Privacy Guidelines and am aware of how my medical records will be used and my ability to obtain my medical records as needed.

Signature_____ Date_____
Patient/Parent/Guardian

ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes direct payment to Kaufmann Physical Therapy. of any insurance benefits otherwise payable to the undersigned for professional service charges. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

Signature_____ Date_____
Patient/Parent/Guardian