CHESTERTOWN PHYSICAL THERAPY SERVICES, INC.

Kent and Queen Anne's Hospital
100 Brown Street
Medical Building
Chestertown, MD 21620
(410) 778-6565

Julia H. Bainbridge
Registered Physical Therapist

PATIENT INFORMATION

Patient Name: _____
(First Name) (Middle Initial) (Last Name)

Sex: Male/Female Date of Birth_____ Age:_____

Social Security#_____ Marital Status_____

Street Address:_____ Home Phone#_____

City/State/Zip: _____ Cell Phone#_____

Employer Name:_____ Work Phone#_____

Spouse's Name:_____ Spouse's Date of Birth_____

Emergency Contact:_____ Phone#_____

Referring Doctor: _____ Primary Doctor: _____

Your Email Address: _____ Please indicate if you would like to have information sent to your email address _____

INSURANCE INFORMATION

(Please give your insurance cards to the front desk to be copied)

Primary Insurance Name:_____ Insured's Name:_____

Policy#_____ Group#_____

Secondary Insurance Name:_____ Insured's Name:_____

Policy#_____ Group#_____

Auto Accident?_____ Worker's Comp?_____ Date of Injury_____

If you have no insurance please see the front desk to make payment arrangements. Copays are expected at the time of each visit. Co-insurance and deductible amounts will be billed after insurance payment or can be estimated and paid at the time of service.

CONSENT TO TREAT, INSURANCE AUTHORIZATION & ASSIGNMENT:

I certify that the above information is correct. I consent to the evaluation and plan of treatment made by my therapist. I authorize the release of medical information required by my insurance company and request payment from my insurance company be made to Chestertown Physical Therapy Services, Inc. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered and any collection fees incurred.

Signature:_____ Date:_____
(Parent must sign if patient is a minor)