Northern Rhode Island Physical Therapy

One Garnett Lane nGreenville, Rhode Island 02828 n Phone 401-949-0380 n Fax 401-949-5581

652 George Washington Highway n Lincoln, Rhode Island 02828 n Phone 401-333-3211n Fax 401-333-5581

Patient Information Sheet

Patient Last Name	First Name	MI
Home Address	CITY / STATE / ZIP	
Home Telephone Number	Other Contact Number(s)	
Occuptaion	Employer	
Work Address	Work Phone Number	
Social Securtiy Number	Date of Birth	Gender
Referring Physician	Diagnosis	

Latex Allergy: YES NO	***EMERGENCY CONTACT INFORMATION***
Pace Maker: YES NO	**EMERGENCY CONTACT:**
Artifical Defibrilator: YES NO	PHONE NUMBER(S):
Do you currently live alone?: YES NO	RELATIONSHIP:

Insurance Coverage *(Please Circle One)*

Major Medical **Medicare** **Self-Pay** **No-Fault**

NOTE: Some insurance coverage may require a pre-authorization, referral or additional paperwork n Northern RI Physical Therapy is required to retain copies of your current insurance card and your driver's license/ID *or* parent/legal guardian driver's license/ID

Is this injury accident-related? (auto, WC, other injury) ***Please circle one***	**Yes** **No**	**Motor-Vehicle** **Other:** **Worker's Comp**

Accident Contact Information: **Claim Number:** ____________________

Contact Name/Title: ____________________ **Contact Number:** ____________________

FINANCIAL AGREEMENT: In consideration of the services rendered by Northern RI Physical Therapy at my request and direction, I understand I am responsible for, and agree to pay in full, to the order of Northern RI Physical Therapy, all charges incurred for services rendered. I further understand that in the even that special arrangements have been made to have payment made through my insurance company (ie, for a worker's compensation or no-fault claim) and the carrier elects not to cover any or all of the claim, I am responsible for the balance in full. I further agree to pay lawfula and reasonable interest charges after thirty (30) days from date of billing on any unpaid balance. In the event that this agreement is placed in the hands of an attorney for collection or enforcement of any of the therms in this agreement, I agree to pay an attorney's fee equal to thirty-three and one-third percent (33 1/3%) of the outstanding balance due.

SIGNATURE DATE SIGNATURE OF PARENT OR GUARDIAN DATE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: Northern RI Physical Therapy is Authorized to provide to my referring physician, insurance company or their representatives, my attorney and/or ______________________________ (other) all information they may have regarding my condition while under their treatment or observation, including, but n ot liminted to, history obtained, medical thermograms, physical findings, diagnosis, and prognosis

SIGNATURE DATE WITNESS DATE

SIGNATURE OF PARENT OR GUARDIAN DATE SIGNATURE OF WITNESS DATE

HOW DID YOU HEAR ABOUT NORTHERN RI PHYSICAL THERAPY

Previous Patient ________ Family Member: __________ Employee: _______ OTHER: ____________________

School: ____________ Newspaper: __________________________ Referral from Dr. ________________________