

# HIGGANUM PHYSICAL THERAPY

P.O. Box 619/23 Killingworth Rd  
Higganum, CT 06441  
(860)345-2622/Fax (860)345-2626

Date: \_\_\_/\_\_\_/\_\_\_

## Patient Information

Name: Last \_\_\_\_\_ First \_\_\_\_\_

Home Address: \_\_\_\_\_

Town: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Employer \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_-\_\_\_-\_\_\_

Emergency: Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Phone# \_\_\_\_\_

How did you hear of Higganum P.T.? \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Primary Doctor \_\_\_\_\_

Area to be treated \_\_\_\_\_ Date of Injury \_\_\_\_\_

## Insurance Information

Auto or Work related? Claim# \_\_\_\_\_

Personal Health insurance Company \_\_\_\_\_

Copy Card **(Patient is responsible for verifying own coverage and copay amount)**

Attorney Name \_\_\_\_\_

## Medical Information

Any medical conditions currently being treated for? \_\_\_\_\_

Please list meds: \_\_\_\_\_

Metal Implants?  Yes  No Pacemaker?  Yes  No Any

Allergies?  Latex  Adhesives  Cortisone  Meds

*I, The undersigned, certify that the above information is accurate to the best of my knowledge and I agree to accept responsibility for any changes for services rendered by Higganum Physical Therapy, Inc. within the terms of the contract of the above listed insurance carrier. I also hereby authorize the release of any and all medical records as necessary to process insurance claims.*

***I understand that I am responsible for being aware of my own insurance coverage/co pay/deductibles amounts. I will contact Higganum P.T. Inc to set up a payment plan if necessary. If I have a concern regarding my coverage I will discuss it with Higganum P.T. Inc before deciding to discontinue with therapy due to financial reasons. I understand that my physician has prescribed a set number of therapy sessions for me and that it is important to the outcome of my recovery that I do my best to complete the prescribed number of sessions and not let financial reasons jeopardize my progress.***

Signature of Patient/Guardian if under 18y/o \_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_