Physical Therapy Works
MANUAL THERAPY EXPERTS

3407 South 84th Street
Omaha, NE 68124
(402)614-8042

PATIENT INFORMATION

Patient's Name:*_____ **Today's date: _____/_____/_____**

Street Address:*_____ **SSN:*_____**

City and State:*_____ **Status: Single Married Other**

Zip Code:*_____ Home Phone:_____ **❍ Male ❍ Female**

Work Phone:_____ Cell:_____ **Birth Date:*_____/_____/_____**

Email:_____ **Age:_____**

Family Physician:_____Location:_____ **Phone(_____) _____**

Employer:_____ Phone: (_____) _____ **Occupation:_____**

Emergency Contact:_____ Phone: (_____) _____ **Relationship: _____**

Result of Auto Accident? Yes____ No____ Date:_____ **Result of Work Injury? Yes____ No____ Date:_____**

*We cannot process your insurance claim without required fields filled out.

Insurance Information

Insurance Company Name:_____

Secondary Insurance Name:_____
(If applicable)

Policy Holder's Name_____ Birth Date*: _____/_____/_____ and SSN:*_____
(If different than patient)

Have you received Home Health Care OR Physical Therapy in the past year? Yes____ No____

If yes, have you been released from care? Yes____ No____

Number of visits used for Home Health_____ Number of visits used for PT_____

The name of the Home Health Care Company that was used:_____

- **I consent to Physical Therapy Works for treatments/procedures that are necessary or advisable for my care. I hereby grant authorization to Physical Therapy Works, Inc. to exchange with and/or release requested information on my medical care to my insurance carrier(s) and to:**
  ❍ Worker's Compensation ❍ Parent/Guardian ❍ Attorney
- **I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to Physical Therapy Works. I understand that I am financially responsible for payment of fees regardless of insurance coverage.**
- **I have read and understand Physical Therapy Work's privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.**
- **I have read and understand Physical Therapy Work's billing and collection policies, initial disclosure, and cancellation and no show policies. I further understand that I may obtain a copy of this policy upon my request.**
- **I have read and understand Physical Therapy Work's information in regards to Dry Needling. I further understand that I may obtain a copy of this information upon my request.**

Signature_____Date_____

Note: If you are 18 years of age or younger, a parent or guardian must sign this patient information on your behalf.