PhysioHealth.Clinic™

PhysioHealth Clinic Providers:
Martin Hehn DC., PLLC
Mikhail Makovski, MD
The Psychiatry Group Inc.
Jeffery E. Fitzthum, MD
PhysioWorks LLC
Dr. Brooks

Patient Information and Consent Form

Only fully completed forms will be accepted. Thank You!

Purpose of Visit ______________________________

PLEASE TELL RECEPTIONIST IF YOU ARE IN PAIN NOW.

Name ______________________________ Date of Birth ______________

Address ______________________________ Apt ________ Drivers Lic# ______________

City ______________ State ________ Zip ________ SS# ______________________

Email Address: ______________________ Cell Phone: ______________ Home Phone: ______________

Email and text to be used for appointment reminders and record requests. Would you like to receive clinic updates/news? Circle: Yes No

How did you hear about us? Doctor Referral: Name of Doctor ______________________________

Website Google Sign Attorney Work Friend Insurance Company Interpreter

Other: ______________________

Employer ______________________________ Occupation ______________________

Emergency Contact ______________________ Phone ______________________________

Please Circle: M / F Single Married

Please Circle: Work Place Injury Auto Accident 3rd Party Injury Personal Injury

Date of Injury __________ Did you have prior treatment or X-rays taken? No / Yes When? __________

Name of doctor with prior x-rays: ____

INSURANCE INFORMATION: ______________________________

Name of Primary Insurance: ______________________________

Company Name: ______________________________

Address ______________________________________

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PIP (Personal Injury Protection) Yes / No_______

Phone___________________Fax#________________Group#___________________Member#_______________________

Secondary Insurance Company______________________________ Address ______________________________

_________________________ Phone_______________ Fax #___________________; Group #______________________;

Member # _______________

** Subscriber Name, Address Primary/Secondary______________City________________State___Zip _

Phone #____________________ Social Security #__________________ Subscriber Date of Birth____________.

Patient Consent and Release

* I give the PhysioHealth.Clinic, Independent Providers permission and authority for my treatment. I will follow reasonable suggestions for care. This office will gladly prepare insurance forms and reports; however, we cannot render services on the assumption that our charges will be paid by and insurance company. All professional services are charged directly to the patient, therefore, the basic responsibility for payment is yours. $25 charge for late (24 Hours) cancellation.

Please initial_________

Assign and Release: I hereby authorize payment of medical services and the release of information to DBA PhysioHealth.Clinic to process claims.

Date ______________________________________ Signature ____________________________________

* Notice of Privacy Practices Acknowledgement *

* The privacy of your health information is important to us. We will maintain the privacy of your health information and we will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so. Please take a moment to review our Privacy Practices. Your signature below documents that you have been offered a copy of this notice.

Date ______________________________________ Signature ____________________________________

* Consent to Treatment of Minors *

* I (We) being the parent of or guardian of___________________________, a minor, the age of_______, do hereby consent, authorize and request PhysioHealth.Clinic Providers., to administer such treatment deemed advisable, necessary or requested on the above minor.

* I (We) agree to hold him free and harmless from any claims, suits for damages or complications which may result from such treatment.

Signature _________________________ Date ______________ Witness ___________Date ___________________

Print Name ________________________ Print Name__________________________________