Championship Physical Therapy
57 Putnam Street
Winthrop, MA 02152

Patient Name:_____

Patient Address:_____

Contact Phone #:_____Date of Birth:_____M/F____

Email: _____Social Security #:_____

In Case of Emergency:_____

Relationship and Telephone Number:_____

Referring Physician:_____Phone No._____

Date of Injury _____Type of Injury:_____Primary Care Physician:_____Phone No. _____

Employment: Full-Time_____ Part-Time _____ Other _____

Insurance Type:_____Insurance ID:_____

Do you have a copayment? Yes____No____ Amount:_____

Subscriber is: Patient_____ Spouse_____Depedent:____Name:_____

Patient is: Married _____ Single _____ Other:_____

Is this injury employment related? YES_____NO _____ If so, Claim #_____

Is this an automobile accident YES_____ NO _____. If so, Claim #_____

**Has there been prior Physical Therapy for this condition or any other? If so, for what, where and when**: _____
_____
_____

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**Are any home services coming to your home? Nursing: Yes/No; Any type of Therapy: Yes/No; Blood Work: Yes/No; Blood Pressure Yes/No**

Consent Release Statement: I hereby authorize Championship Physical Therapy to perform any therapeutic procedure or treatment that is consistent with my diagnosis. I understand that I will be given the opportunity to ask questions regarding my treatment and that my physical therapist will be available to answer my questions. I understand that I can terminate any treatment at any time I so desire.

For services rendered or to be rendered, I authorize payment of medical benefits to be paid to Championship Physical Therapy, LLC. I authorize the release of the P.T. evaluation progress notes/plan of care to Doctor's offices, utilization review and insurance companies. I understand that I am responsible for my bill for physical therapy services, and I understand that I am responsible for any unpaid deductibles. I also understand that any balance of the bill that my insurance company does not pay is due with 30 days upon receipt of a billing statement.

PATIENT'S SIGNATURE: _____DATE:_____

OR AUTHORIZED
PARENT/GUARDIAN: _____DATE: _____

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, _____, have received the Notice of Privacy

Practices from Championship Physical Therapy.

X_____ Date: _____

In lieu of patient signature I, _____, a staff member of

Championship Physical Therapy, state that _____has
Been given our current Notice of Privacy Practices.

X_____ Date:_____