

Name: _____

Spouse Name: _____ Spouse's Employer _____

Spouse's Employer's Address: _____

Street City State Zip

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____ Phone: _____

Have you had treatment for this condition in the past?: Yes No, where _____

How many times have you tripped or fallen (either against an object or to the floor) in the past year: 0 1 2 or more

Have you had an injury do to a fall? Yes No

Are you allergic to latex? Yes No

Who referred you? (Please check only one)

- Home Health agency Hospital Previous patient
 Friend / Relative Insurance Company Physician: (Name _____)

How did you hear about Professional Therapy Services? (Check all that apply)

- Newspaper Ad Friend / Relative Insurance Company
 Yellow Pages Television Radio
 MD Other: _____

Medicare Registration Questionnaire:

Have you had ANY therapy this year at: Chiropractor Physician Other _____

Do you have a nurse or aide coming to your home?

Have you had any Home Health Services in the past month? If so, what agency? _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize you to pay directly to the below named outpatient therapy office all and any benefits due out of indemnity under the terms of my policy by your company.

**Professional Therapy Services, Inc.
2810 Frank Scott Parkway West
Suite 824
Belleville, IL 62223**

Payment is authorized upon your receipt of any and all of our itemized statements for services rendered to us. This policy was in full force and effect at the time those services were rendered. Payment of this amount is herein directed in whole or part shall be considered the same as if paid by your company directly to me.

I also hereby certify that all information is correct and complete, that I hereby give my consent for treatment with therapy to be administered by persons in this office in acceptable professional standards. I hereby authorize release of any medical information necessary to process this claim. I am responsible for payment of any sum due upon demand for goods and services rendered. If litigation is required to collect any amounts due under this contract, I consent to St. Clair County, Illinois as being the proper venue for the filing of any action. In the event after reasonable demand I fail to pay any sum due and my account if placed in the hands of a collection agency, I agree to pay reasonable collection fees incurred in the collection of any such sum due or part thereof and interest to 1.5% per month on any unpaid balance past 30 days.

SIGNATURE: _____ DATE: _____

04/09