PHYSIOTHERAPY NEW MEXICO
9 Frasco Way
Santa Fe, NM 87508

Medical Record#:______________________

Email:________________________________

PATIENT INFORMATION			**PERSON RESPONSIBLE FOR BILL**	
Name:		Marital Status: M S D W	Name:	
Address:			Address (city, state, zip):	
City:	State:	Zip:	Home Phone:	Work Phone:
Age:	Date Of Birth:	Sex: M F	Relationship To Patient:	
Email:	Home Phone:		Email:	Date Of Birth:
Medication Allergies:			Insurance Effective Date:	
			Policy#:	
Employer:			Group#:	
Work Phone:				
Cell Phone:				
IN CASE OF EMERGENCY PLEASE NOTIFY:				
Name:			Relationship:	
Home Phone:			Work Phone:	
Signature of person completing form:			Date:	

Acknowledgement Of Receipt Of Notice Of Privacy Practice:

I, ____________________________Acknowledge that I have received a copy from PHYSIOTHERAPY NEW MEXICO "Notice Of Policy Practices". This notice describes how PHYSIOTHERAPY NEW MEXICO may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

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Signature of Patient, or Personal Representative   Relationship To Patient   Date

We accept assignment for those plans for which we are panel providers. All co-payments and uncovered portions are due at the time of service. I, the undersigned, assign directly to PHYSIOTHERAPY NEW MEXICO, payment for all covered benefits if any, for services rendered and/or materials provided. I understand and agree that I am financially responsible for this account for any amounts due whether or not paid by insurance. I hereby authorize release for information necessary to process claims for services and material provided.

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Signature   Relationship To Patient   Date