GREENWICH PHYSICAL THERAPY CENTER, P.C.

Scott H. Gelbs, PT, DPT, OCS, PCC
Director of Physical Therapy

PATIENT INFORMATION SHEET

Name:______________________________________ **Date of Birth:**______________

Address: ____

City: ____________________________ **State:** _____ **Zip Code:** _________________

Home Phone: _________________________ **Business Phone:** ________________

Email Address: ________________________ **Cell Phone:** _____________________

Employer Name: ____

Occupation: ____

S.S. Number: ________________________ **Marital Status: S M D W** (Please circle)

Referring Doctor's Name: ____

Is your condition the result of a/an: (Please circle)

- **A) Automotive accident?** Y N
- **B) Motorcycle accident?** Y N
- **C) Work related accident?** Y N
- **D) Other** Y N (If yes please explain)

____

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HEIGHT __________

WEIGHT __________

1171 East Putnam Avenue • Riverside, CT 06878 • (203) 637-1700 • Fax (203) 637-5447

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It is the policy of Greenwich Physical Therapy Center that all payments for services rendered be made on a weekly basis.

If your insurance coverage is one that **we** participate with, then you will only be responsible for your co-payment and any deductible that has not yet been met.

If your insurance coverage is one that **we do not** participate with, then on the final office visit each week, you will be responsible to make payment in full. We will then provide you with a statement to submit to your insurance company for **your reimbursement.**

It is also the policy of Greenwich Physical Therapy Center that equipment issued to a patient be paid in full upon receipt.

For those patients covered by Medicare, Greenwich Physical Therapy Center, as required by law, will submit bills directly to Medicare. Greenwich Physical Therapy Center will await payment from Medicare. Whatever balance is not covered by Medicare and your supplemental will be billed to you.

FOR YOUR PAYMENT CONVENIENCE WE ACCEPT CHECKS, VISA AND MASTERCARD.

I hereby acknowledge that I am financially responsible for any unpaid balance. I authorize Greenwich Physical Therapy Center to administer physical therapy care and further authorize them to release any information required by my insurance carrier.

I ______________________________, hereby declare that I am not receiving Medicare Health Insurance benefits. If my status changes, I am aware that I must notify GPTC immediately. GPTC will not be held responsible for any charges in the event that I do not notify the office that my benefits have changed.

______________________________ ______________________

PATIENT SIGNATURE **DATE**
(Parent or Guardian if patient is a minor)

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