PATIENT INFORMATION FORM

Buddies In Motion Pediatric Physical Therapy
Baraka Physical Therapy LLC
33-47 91 St. - Ground floor
Jackson Heights, NY 11372
Phone: (347) 495-2219 or (347) 242-3733
Fax: (347) 242-3733

Full Name: _____ **Date of Birth:** _____

Address: _____ **State:** _____

City: _____ **Zip:** _____

Parents/ Guardians Name: _____

Home / Cell Phone: _____

Email Address: _____

Referring Physician _____

Name: _____

Phone: _____

Reason for Referral _____

_____

Parential Concerns _____

_____

Has the child received any physical therapy before?
¿Ha recibido el niño alguna terapia física antes?

Yes ◯ **Si** **No** ◯

If yes, please provide the following information:
En caso afirmativo, proporcione la siguiente información:

Name of Clinic / Nombre de la clínica _____

Phone Number / Número de teléfono _____

Date of Last Visit
Fecha de la última visita _____

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Name of Insured: _____

Carrier Name: _____ **ID#:** _____

Name of Person Responsible for Payment: _____

I agree to accept responsibility of payment for
services rendered by Baraka Physical Therapy LLC

Signature: _____

Date: _____

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on this account for any professional services rendered. I have read all the information and completed the bove questions. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes to the above.

Signature: _____

Date: _____

AUTHORIZATION FOR USE OF SIGNATURE ON FILE FOR CLAIM AUTHORIZATION

Enrollee social security # _____

Enrollee Name: _____

I, _____ authorize Baraka Physical Therapy, LLC to mark the section "Enrollee or authorized person's signature" with the notation "**Signature on File**"

This section authorized:

1. The release of any medical information necessary to process this claim;
2. Payment of medical benefits to the undersigned physician or supplier of services described below
3. This authorization will remain in force until terminated in writing by the enrollee.

Enrollee Signature: _____

Date: _____