

**PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ SEX (M/F): \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
STREET ADDRESS: \_\_\_\_\_ SSN: \_\_\_\_\_  
CITY, STATE, ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_  
MAILING ADDRESS (IF DIFFERENT FROM ABOVE): \_\_\_\_\_ CELL: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_  
SPOUSE: \_\_\_\_\_ PHONE: \_\_\_\_\_  
ADDITIONAL CONTACT (OUTSIDE OF HOME): \_\_\_\_\_ PHONE: \_\_\_\_\_  
E-MAIL ADDRESS (OPTIONAL): \_\_\_\_\_

**\*HOW DID YOU HEAR ABOUT US?**    RADIO    NEWSPAPER    PHONE BOOK    REFERRAL (FRIEND/DOCTOR)    OTHER

**RESPONSIBLE PARTY INFORMATION**

IF **MINOR OR COLLEGE STUDENT** ENTER PARENT NAME: \_\_\_\_\_  
PARENT ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
PARENT EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

**BILLING INFORMATION**

INSURANCE COMPANY: \_\_\_\_\_ INSURED NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
GROUP: \_\_\_\_\_ ID/CLAIM NUMBER: \_\_\_\_\_ ACCIDENT DATE: \_\_\_\_\_ PHONE: \_\_\_\_\_

**IMPORTANT INFORMATION PLEASE READ**

1. I consent to examination, treatment and procedures which may be performed during office visits considered necessary by the physical therapist.
2. I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
3. I understand that I am financially responsible for all charges whether or not paid by my insurance.
4. I understand that should I default on payment of my account and collection agency services are required, all costs of collections, up to 45% of the balance, including attorney/court costs will be added to the balance of my account.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICE USE ONLY**

DIAGNOSIS: \_\_\_\_\_ ICD9: \_\_\_\_\_  
MEDICAL RECORD #: \_\_\_\_\_ PRIMARY THERAPIST: \_\_\_\_\_ PHYSICIAN: \_\_\_\_\_