Preferred Physical Therapy

Our mission is to heal. Our passion is to care

Patient Information Form

PATIENT INFORMATION

Patient Name ______________________ Soc. Sec. # ______-______-______

Address ______________________ Home Phone ______________________

City ______________________ State __________ Zip ______________________

Birthdate ______________________ Age _________ Married ☐ Single ☐ Other ______________

Cell Phone ______________________ Work Phone ______________________

Employer ______________________ Full-time ☐ Part-time ☐ Retired ☐

Responsible Party (if other than patient) ______________________

Email Address: ______________________

APPOINTMENT REMINDERS

Would you like appointment reminders? Yes ☐ No ☐

If yes, please check how you would like to contacted: Email ☐ Voice ☐ Text ☐

Please provide the email address/phone number you would like us to set up reminders for:

____

PRIMARY INSURANCE

Insurance Co. ______________________ Co-Pay ______________________

Address ______________________ Phone ______________________

City ______________________ State ____________ ZIP ______________________

Policy # ______________________ Group # ______________________

Work Related? Yes ☐ No ☐ Automobile Accident? Yes ☐ No ☐

Insured Name ______________________

Date of Birth ______________________ Relationship ______________________

SECONDARY INSURANCE

Insurance Co. ______________________ Co-Pay ______________________

Address ______________________ Phone ______________________

City ______________________ State ____________ ZIP ______________________

Policy # ______________________ Group # ______________________

Work Related? Yes ☐ No ☐ Automobile Accident? Yes ☐ No ☐

Insured Name ______________________

Date of Birth ______________________ Relationship ______________________

AUTHORIZATION

Insurance Assignment and Medical Records Release:

I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to Preferred Physical Therapy the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including co-pay and/or deductible amounts. I, the undersigned, agree to pay all attorneys fees, court costs, filing fees, including charges or commissions that may be assessed to me by any collection agency retained to pursue such matters. I further agree to pay interest in the amount of 1.5% per month on any balance over 90 days.

I, the undersigned, do hereby give my permission to Preferred Physical Therapy to furnish my insurance carrier(s) any and all information pertaining to my medical records.

I, the undersigned, have been given the opportunity to read, review and receive a copy (if desired) of the Notice of Privacy Practices for Preferred Physical Therapy.

Signature: ______________________ Date: ________________