PATIENT INFORMATION:

______New Patient _____ Updated Info:

Name: ____ **Date of Birth**: __________________________

Social Security Number: _________________________ **Marital Status**: _________________________

Cell #: __________________ __ **Sex**: Male / Female **Home Phone:** __________________________

Address: ____ ________________________________
(city, state, zip)

Driver License #: _____________________ **Employer:** ____

Work Phone: _______________ **Emergency Contact:** _____________________ **Phone** _______________

Referred By: ____

RESPONSIBLE PARTY/GUARANTOR INFORMATION

Name: _____________________________ **Sex: Male / Female Date of Birth:** _____________________

Relationship to Patient: _____________________ **Social Security #:** ______________________________

Address: _____________________________________ ____
(city, state, zip)

Home Phone: ________________________________ **Employer:** _________________________________

Employer Address: ____

Work Phone: ____________________________ **Cell #:** ______________________

INSURANCE INFORMATION

Primary Insurance Co: ____________________________ **Policy Holder:** ___________________________

Date of Birth: ___________ **Policy / Identification No.:** __________________ **Group No:** ____________

Secondary Insurance Co: __________________________ **Policy Holder:** ____________________________

Date of Birth __________ **Policy/ Identification No.:** ___________________ **Group No.:** ______________

***Additional Information*:**
Were you injured on the job? Yes No Date: _________________
Were you injured in an automobile accident? Yes No Date: _________________
When did you first consult your physician for this condition? Date: _________________

STATEMENT OF POLICY:

I understand that I am personally and directly responsible for all health care bills submitted by Specialized Physical Therapy for services rendered to me and that I have the primary duty and obligation to pay my therapist for these services not withstanding any contract that I may have with any Third party, such as an Insurance Company, Employer, Union or Government. If my account is delinquent over 60 days, a percentage rate of 1.33% monthly (16% annually) will be added to my bill and, if my account must be turned over for collection, the cost of collection will be added to my bill as a direct expense to me.

Because of scheduling procedures, charges of $75.00 will be made for missed appointments, unless 24 hours' notice is given.

I authorize this office to render medical treatment and care, and to release any medical information to process this claim. I also request payment of medical benefits be assigned to the undersigned therapist.

Signature: ____ ***Date:*** ____________________________