PATIENT INFORMATION

NAME_____DATE OF BIRTH_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____SOCIAL SECURITY #_____

OCCUPATION_____EMPLOYER_____

WORK ADDRESS_____CITY_____STATE_____ZIP_____

WORK PHONE_____ E-MAIL ADDRESS_____

CELL PHONE_____ REFERING MD_____

PCP_____HOW DID YOU HEAR ABOUT US?_____

Please initial if you prefer to receive your Statement via email instead of Postal Mail. Please note that email is not HIPAA regulated or secure. INITIAL HERE: _____

EMERGENCY DATA

IN CASE OF EMERGENCY CONTACT:

NAME_____ PHONE NUMBER_____

ADDRESS_____ CITY_____STATE_____ ZIP_____

RELATIONSHIP_____

INSURANCE DATA

NAME OF INSURANCE COMPANY_____

POLICY NUMBER_____SUBSCRIBER'S NAME_____

WAS INJURY DUE TO AN AUTO OR WORKERS COMP ACCIDENT?
IF YES, PLEASE FURNISH THE FOLLOWING:

DATE OF INJURY_____ FILE CLAIM NUMBER_____

INSURANCE COMPANY_____

ADDRESS TO SEND BILLS_____CITY_____STATE_____ZIP_____

CLAIMS ADJUSTER'S NAME_____PHONE NUMBER_____

PRE-CERT CO._____PHONE NUMBER(_____)_____

I HEREBY AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO DOWNTOWN PHYSICAL THERAPY, FOR SERVICES RENDERED.

I HEREBY AUTHORIZE DOWNTOWN PHYSICAL THERAPY TO RELEASE (OR OBTAIN) INFORMATION REGARDING MY PHYSICAL THERAPY EVALUATION AND TREATMENT AND RELATING BILLING INFORMATION TO (FROM) MY ATTORNEY, OR INSURANCE CARRIER FOR PURPOSES OF PROCESSING THIS CLAIM.

SIGNATURE_____DATE_____