



Patient Information

Please bring a hard copy of this to your appointment. To maintain your privacy, please do not email or fax this form to us.

Name: _____
Last name First Middle Initial

Address: _____

City: _____ State _____ Zip Code _____

Home Phone: _____ Cell Phone _____

May we leave you a message on this phone number or just leave a call back number? Y or N

If NO, alternative phone or address: _____

Age: _____ Birth Date: _____ Gender (circle one) Female Male

Occupation: _____ Employer: _____ Work# _____

SSN # _____ Marital Status: _____

E Mail Address _____

Emergency Contact: _____ Phone: _____

Referring Physician or Provider

Name: _____ Phone: _____

Accident/Injury Information (if applies)

Is your condition related to the following...

Work related injury? Y or N Are you able to continue working? Y or N

Automobile accident? Y or N

Date of injury: _____ Place where occurred _____

Insurance/Billing Information

Primary Insurance Co. _____ # _____

Are you the primary card holder for this insurance? Y or N

If no, the subscribers name is: _____

Relationship to you is: _____ Subscriber's date of birth _____

Secondary Insurance Co. _____ # _____

Appointments need to be kept to achieve your goals for recovery. Advanced 24 hour notice is required for all cancellations. A Fee of \$30 will be charge if cancellations become excessive.

Notice of Privacy Practice- Your personal health information (PHI) is protected and is used exclusively to administer physical therapy services and process your claims. Unauthorized disclosure of PHI is strictly prohibited. A complaint can be filed with the Privacy Officer in person or in writing at any time you feel your PHI is not being protected and the complaint will be met with full respectful attention without retaliation. The full Flex Privacy Policy is available upon request.

Release and Consent- I authorized release of my medical records to my insurance provider at the minimum required to process my medical claim. Flex Physical Therapy will, as a courtesy, verify my insurance benefits. But this is in no way a guarantee of payment. I will keep in direct contact with my insurance provider to ensure payment and will obtain any authorizations or referrals my insurance company may require. I am financially responsible for all co-pays and any co-insurance balance due per my contract, with my insurance provider, and for any balance not paid by my insurance provider. I agree to pay for all collection costs incurred by Flex Physical Therapy in the collection of any balance I owe.

I consent to treatment at **Flex Physical Therapy**.
If the patient is a minor, I hereby authorize treatment as his/her parent or legal guardian.

Signature/Parents sign if minor

Date