



Patient Information

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
Emergency Contact: _____ Phone: _____
Please complete the following: (Note: if patient is a minor, please complete with guardian information)
Occupation: _____ Employer: _____ Work# _____
SSN # _____ Marital Status: _____
E Mail Address _____
Parent Name (if applicable): _____

Referring Physician or Provider

Name: _____ Phone: _____

Accident/Injury Information (if applies)

Is injury: Work related Y or N Automobile accident related Y or N
If yes to either, please provide Claim# _____
Claims Manager Name: _____ Phone: _____
Date of injury: _____ Place where occurred _____
Are you able to continue working? Y or N

Insurance/Billing Information

Primary Insurance Co. _____ ID# _____
Group # _____ Are you the primary card holder for this insurance? Y or N
If no, subscribers name: _____ Subscriber's date of birth _____
Subscriber's Employer: _____ Relationship to you is: _____
Secondary Insurance Co. _____ ID# _____ Group _____
Secondary Subscriber Name: _____ Subscriber's date of birth: _____

Appointments need to be kept to achieve your goals for recovery. Advanced 24 hour notice is required for all cancellations.
A Fee of \$50 will be charge if cancellations or no shows become excessive. **** Please initial _____ ****

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 herby authorize treatment as his/her parent or legal guardian.

Signature (Guardian must sign if minor) Date