

Thank you for selecting **FORM AND FITNESS PHYSICAL THERAPY**. We will strive to provide you with excellent service. We are dedicated to giving each Patient a personal service that they can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask-we will be happy to assist you.

### Patient Information

Name Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ DOB: Mo \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Legal Guardian/Responsible Party \_\_\_\_\_

Current address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone H \_\_\_\_\_ W \_\_\_\_\_ Cell \_\_\_\_\_

Social Security \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Student \_\_\_ Single \_\_\_ Married

Emergency Contact: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_ 2<sup>nd</sup> Emergency Phone: \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer address \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

### General Information

Referring Doctor \_\_\_\_\_ Family Doctor \_\_\_\_\_

Description of Problem \_\_\_\_\_

On Going Problem/Injury? \_\_\_\_\_ Work Accident \_\_\_ Auto \_\_\_ Other \_\_\_\_\_

#### Medical /Health Insurance

Insurance Company \_\_\_\_\_ PPO \_\_\_ HMO \_\_\_ Other \_\_\_\_\_

Policy /ID Number \_\_\_\_\_ Group Number \_\_\_\_\_

Primary Insurance Holder \_\_\_\_\_ D.O.B. \_\_\_\_\_

S.S. \_\_\_\_\_

Secondary Insurance (if applicable) \_\_\_\_\_

Policy/ID Number \_\_\_\_\_ Phone Number \_\_\_\_\_

**Medical Release of Information:** I authorize the release of any medical information necessary to process this claim.

**Assignment of Benefits:** I hereby assign payment directly to FORM AND FITNESS PHYSICAL THERAPY, who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand that if this is a motor vehicle accident and the medical benefits are exhausted such that financial responsibility reverts to my health insurance, I am financially responsible for any applicable deductibles or co-pays. I also understand that I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

#### **Missed Appointments**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.

Patient (Legal Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_