PATIENT INFORMATION

*PATIENT NAME _____ MALE/FEMALE? *DATE _____

*ADDRESS _____ * DATE OF BIRTH _____

*CITY _____ *STATE _____ *ZIP _____

* **REMINDER NOTIFICATION PREFERENCE (PLEASE CHECK ONE):** □ EMAIL □ TEXT □ PHONE-CALL

*HOME PHONE _____ * CELL PHONE _____ *WORK PHONE _____

*EMAIL ADDRESS _____ * DRIVERS LICENSE # _____

*SOCIAL SECURITY NUMBER _____ REFERRING DOCTOR _____

LOCATION OF PAIN/INJURY _____ INJURY DATE_____ SURGERY DATE _____

IS THIS A WORK RELATE INJURY? YES NO IS THIS INJURY FROM A CAR OR OTHER ACCIDENT? YES NO

EMPLOYER _____OCCUPATION _____

ATTORNEY NAME _____ PHONE _____

*EMERGENCY CONTACT NAME _____ *PHONE _____

INSURANCE INFORMATION

NAME OF RESPONSIBLE PARTY_____ RESPONSIBLE PARTY S.S. #_____

PATIENTS RELATIONSHIP TO INSURED_____

INSURANCE COMPANY _____PHONE _____

I GIVE PERMISSION TO PACIFIC PHYSICAL THERAPY TO RELEASE INFORMATION TO MY INSURANCE COMPANY, ATTORNEY, ASSIGNEES, AND/OR BENEFICIARIES. I AUTHORIZE PAYMENT DIRECTLY TO PACIFIC PHYSICAL THERAPY FOR SERVICES THAT I OR A DEPENDENT HAS RECEIVED BY MY INSURANCE CARRIER. IN CONSIDERATION OF THEIR SERVICES RENDERED AND TO BE RENDERED TO THE ABOVE NAMED PATIENT BY PACIFIC PHYSICAL THERAPY, I EXPRESSLY GUARANTEE PAYMENT OF THIS ACCOUNT AND AGREE TO PAY ANY CHARGES LEFT UNPAID IN WHOLE OR IN PART BY MY INSURANCE CARRIER. I UNDERSTAND THAT PACIFIC PHYSICAL THERAPY WILL VERIFY BENEFITS AND COVERAGE WITH MY INSURANCE CARRIER, BUT THAT THIS DOES NOT GUARANTEE PAYMENT BY MY INSURANCE CARRIER. I ALSO UNDERSTAND THAT I MAY BE LIABLE FOR REASONAL COLLECTION FEES, INTEREST AND OTHER COSTS FOR UNPAID DEBT INCURRED. I ALSO UNDERSTAND THAT PACIFIC PHYSICAL THERAPY HAS A 24 HOUR CANCELLATION POLICY AND THAT I MAY BE LIABLE FOR A $50.00 NO-SHOW/CANCELLATION FEE FOR REPEAT OFFENSES OF THIS POLICY PRIOR TO ANY FURTHER APPOINTMENTS SCHEDULE.

SIGNATURE OF PATIENT OR PERSON RESPONSIBLE FOR PATIENT _____

PRINT NAME _____ DATE _____