Our Staff would like to welcome you to PTII.

PATIENT INFORMATION *(Please fill out both sides completely.)*

Today's Date: Clinic:

Name:

Address: Apt. #:

(City) (State) (Zip)

Home Phone #: Work Phone:

Social Security #: Birth Date:

Marital Status: M S W Sex: F M

Employer/School: Occupation: Dept:

Address:

(City) (State) (Zip)

Name of referring physician:

How did you hear of us?

Have you been treated *atPTIIbefore?* If so, when and which location?

Would you like copies of correspondence sent to your primary care physician? If so, supply information below:

(Name) (Address) (City) (State) (Zip) (Phone)

Date of Injury:

Is this worker's compensation? Yes No Company Name

Auto Accident? Yes No.

Is this a lawsuit? Yes No Attorney's Name: Phone:

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INSURANCE INFORMATION

Primary Insurance Company Name:

Name of Policy Holder: Relationship:

SS#: Date of Birth:

Ins Co Phone: ID#: Group #:

Secondary Insurance Company Name:

Name of Policy Holder: Relationship:

SS#: Date of Birth:

Ins Co Phone: ID#: Group #:

IF WORKMAN'S COMPENSATION:

Workman's Compensation Insurance Company Name:

Claims Adjuster Name: Phone #: Claim#:

Rehab nurse name: Phone #:

~TII FINANCIAL POLICY

- Patients with health insurance should remember that services rendered are charged to you, the patient, not your Insurance company.
- As a courtesy to our patients we will file physical therapy claims for you, but we do not accept the responsibility for settling the claim with your carrier.
- If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.
- We require 24 HOUR notice for any cancellation. A $15.00 fee will be charged to your account for failure to comply.

Your signature is required below to authorize treatment. Your signature also authorizes the release of medical information needed to process your claim, allowing an assignment of benefits where a claim has been filed, and acknowledging your understanding of the above office policies.

Patient Signature Date

The following signature authorizes the release of information stated above and for treatment, if the patient is a minor.

Signature Parent/Guardian Date