

Date _____

Soc Sec # _____

PATIENT INFORMATION (CONFIDENTIAL)

Name _____ Phone _____ Email _____
FIRST NAME MIDDLE INITIAL LAST NAME

Address _____ City _____ State _____ Zip _____

Check Appropriate Line: ___ Minor ___ Single ___ Married ___ Divorced ___ Widowed ___ Separated

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Person To Contact in Case of Emergency _____ Phone _____

Whom May We Thank for Referring You? _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Employer _____ Work Phone _____ SS# _____

For your convenience, we offer the following methods of payment. Please check the option you prefer. **Co-Pay in full at each visit.**

___ CASH ___ Personal Check Credit Card: ___ VISA ___ MasterCard ___ I wish to discuss the office payment policy.

INSURANCE INFORMATION (We request your insurance card(s) to make a copy for your file.)

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Policy# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___ YES ___ NO IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Name of Employer _____ Policy# _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize Clinton Physical Therapy Center to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Clinton Physical Therapy Center insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I have been provided with the **Insurance and Financial Policy** and agree to the terms as stated.

Signature of patient (or parent if minor)

Date