RESTORATIVE
PHYSICAL THERAPY & REHABILITATION

NEW PATIENT FORM

NAME_____ MALE / FEMALE (circle)

ADDRESS_____

PHONE (home)_____ PHONE (mobile) _____

EMAIL ADDRESS_____

DATE OF BIRTH _____ / _____ / _____ SSN # (if workman's comp) _____

INSURANCE SUBSCRIBER'S NAME (if different from patient named above) _____

ADDRESS OF INSURANCE SUBSCRIBER _____

EMERGENCY CONTACT FULL NAME_____

RELATIONSHIP TO PATIENT_____ PHONE_____

REFERRING PHYSICIAN_____

DATE OF INJURY/ACCIDENT (if auto or workman's comp) _____ / _____ / _____

PATIENT'S EMPLOYER_____

PATIENT'S OCCUPATION_____

EMPLOYER'S ADDRESS (if workman's comp) _____

CO-PAY, CO-INSURANCE, AND DEDUCTIBLE

I understand that my health insurance may have a co-pay, co-insurance, or deductible for which I may be personally responsible. I also understand that it is my responsibility to call the member services department of my insurance company to verify the specifics of my physical therapy coverage, which may differ from my physician coverage.

INITIALS_____ DATE_____ / _____ / _____

ASSIGNMENT AND RELEASE AUTHORIZATION

I, the undersigned, have insurance coverage with the company presented upon the first visit and assign direct payment for all physical therapy benefits to Restorative Physical Therapy & Rehabilitation for services rendered to myself or a dependent.

I understand that I am financially responsible for all charges, whether paid or not, by the insurance company whether the insurance company deems them medically necessary or not. Furthermore, I understand that I am financially responsible for all charges.

I authorize Restorative Physical Therapy & Rehabilitation to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I have read and understand the privacy policies regarding my health care at Restorative Physical Therapy & Rehabilitation.

SIGNATURE OF PATIENT OR GUARDIAN_____ DATE_____ / _____ / _____