Patient Information (please print)

Patient Name: _____
Last First MI

Social Security # : _____ Date of Birth: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Doctor: _____ Doctor Phone: _____

Responsible Party Information

Responsible Party Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer's Name: _____

Insurance Information

Health Insurance Auto Work Comp Self-Pay

Name of Insured or Policy Holder: _____

Policy or ID Number: _____ Group Number: _____

Insurance Company Name: _____

Insurance Company Phone: _____ Contact Name (if any): _____

Claims Address: _____

City: _____ State: _____ Zip: _____

AUTO AND WORK COMP *Date of Injury:* _____

Authorization of Benefits: *Yes* *No* *Claim Number:* _____

Authorization Number: _____ *No. of Authorized Visits:* _____

Name of Adjuster: _____ *Adjuster's Phone:* _____

Authorization of Benefits and Release of Medical Information

I acknowledge that the above information is true and correct.

I authorize release of my medical records to my insurance company or, if a work comp or auto related injury, to my employer or claims adjuster, respectively. I further authorize release of my medical information, including summary Progress Notes, to my referring physician or other medical providers involved in my current plan of care.

I hereby irrevocably assign all benefits directly to Performance Physical Therapy, Inc. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance due on my account for all professional services rendered.

_____

Signature(s) of Patient and Responsible Party Date