PerformanceWest Physical Therapy Patient Information Sheet

This form must be filled out **completely** and accurately in order for us to bill your insurance company for services rendered.

PATIENT INFORMATION

(PLEASE PRINT LEGIBLY)

Name:_____ Age:_____ Date of Birth: ____/____/____

Gender: M F Marital Status:_____ Social Security #_____

Street Address:_____

City_____State_____Zip_____

Mailing Address: (if different) _____

Home Phone:_____ Cell Phone:_____ Email:_____

Employer:_____Work Phone:_____

Emergency Contact_____ Phone #:_____ Relationship:_____

POLICYHOLDER/PARENT/GUARDIAN INFORMATION

Name:_____ Relationship to Patient:_____

Policyholder: _____ Policyholder Date of Birth: ____/____/____

Is address same as patient's? YES NO (If no, please complete below)

Address:_____City:_____State:_____Zip:_____

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

SYMPTOMS/ SURGERY/INJURY OR ACCIDENT INFORMATION

Referring physician _____

Who referred you to our office? _____ Treatment area: _____

Date of symptoms, surgery, injury or accident (**please be specific**):_____/_____/_____

If due to surgery, where was your surgery performed? _____

Briefly describe your symptoms:

_____

PRIMARY INSURANCE INFORMATION

Insurance Company:_____ Phone #:_____

Address:_____ City:_____State:____Zip:_____

Policyholder:_____ Policyholder Date of Birth: ____/____/____

Policy # or ID#:_____ Group#_____

SECONDARY INFORMATION (if applicable)

Insurance Company:_____ Phone # _____

Address:_____ City:_____State:_____Zip:_____

Policyholder:_____ Policyholder Date of Birth: ____/____/____

Policy # or ID#:_____ Group#_____

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY BEFORE SIGNING (ASK FOR CLARIFICATION IF UNCLEAR)

A) I consent to physical therapy evaluation and treatment provided and directly supervised by a licensed physical therapist employed by PerformanceWest Physical Therapy.

B) I agree that I am responsible for this debt regardless of insurance or other reasons and that I will pay any unpaid balance, in full, within 60 days of the date of service. I agree to pay 18% interest per annum on the unpaid balance, compounded monthly.

C) In the event that my account is not paid as agreed or is delinquent, I agree to pay reasonable and standard collection agency, attorney, arbitration, mediation and court fees incurred for the collection of this debt.

D) I agree and understand that a **$20.00 fee** can be assessed if I do not provide 24 hour prior notice to cancel an appointment. This fee will **not** be covered by insurance. I also understand that I may be asked to reschedule my appointment if I am late.

E) In the event that industrial or auto insurance benefits are exhausted or there is a refusal to pay for service, I authorize PerformanceWest Physical Therapy to bill my health insurance and give permission to release information to 3rd party carriers and assign all insurance benefits for services to be paid directly to the above named provider. I certify that a copy of this assignment shall be as valid as the original.

_____ _____/____/_____
Signature Date

_____ _____
Parent or Guardian Signature if under 18 years of age Relationship to Patient

I acknowledge that I have read and/or received a copy of the Notice of Privacy Practices:_____ Date: _____