

EAGLE CENTER PHYSICAL THERAPY
PATIENT INFORMATION SHEET

PATIENT NAME _____ SEX M / F

MAILING ADDRESS _____

CITY/STATE/ZIP _____ PHONE _____

SS# _____ BIRTH ____/____/____ CELL PHONE _____

EMAIL ADDRESS: _____

PATIENT EMPLOYER _____ PHONE _____

CONTACT IN CASE OF EMERGENCY _____ PHONE _____

DATE OF INJURY/SURGERY _____

INJURY/SURGERY WAS: Work related (____) Automobile accident (____) Other _____

REFERRING DOCTOR _____ HOW DID YOU HEAR ABOUT US? _____

SPOUSE OR PARENT INFORMATION

RELATION _____ NAME _____ SS# _____ M

MAILING ADDRESS: (Fill in only if different than Patient Address) _____

CITY/STATE/ZIP _____ PHONE _____

INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE CO. _____

INSURED: _____ D.O.B _____ **COPY OF INS CARD ATTACHED** _____

PATIENT/INSURED RELATIONSHIP: _____
(Fill in only if copy of card not attached POLICY /ID # _____ GROUP _____)

SECONDARY INSURANCE CO. _____

INSURED: _____ D.O.B _____ **COPY OF INS CARD ATTACHED** _____

PATIENT/INSURED RELATIONSHIP: _____
(Fill in only if copy of card not attached POLICY /ID # _____ GROUP _____)

WORKER'S COMPENSATION / AUTO ACCIDENT

EMPLOYER NAME _____ PHONE _____

INSURANCE CO. _____ PHONE _____

ADJUSTOR (CASE WORKER) _____ CLAIM NO. _____

We are responsible for contacting your insurance company and confirming your physical therapy coverage and any policy limits.

CONSENT FOR TREATMENT

I hereby authorize any physical therapist employed by Eagle Center Physical Therapy to administer care as deemed necessary. I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance on my account. Returned checks will be charged \$25.00 per month and BALANCES OLDER THAN 30 DAYS WILL BE SUBJECT TO ADDITIONAL COLLECTION FEES OF \$35.00 PER MONTH. I have read all the information and I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

SIGNATURE

DATE