We welcome your co-pay during each visit.

PATIENT INFORMATION

Name:____ Date of Birth:___________ Sex: _______
Address:____ Home Phone: _______________________
Employer:____ Cell Phone:_________________________
Address:____ Business Phone:_____________________

Referring Physician:______________________________ Phone:_______________________________
Address:____ Fax:_________________________________

Primary Physician:________________________________ Phone:_______________________________
Address:____ Fax:_________________________________

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Have you had physical therapy anywhere in the past 12 months? ______________________________
Was this injury employment related?_______ Was this injury due to a motor vehicle accident?______
Please provide billing information if claim is being processed through worker's compensation or motor vehicle insurance:____
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- I understand that I am responsible for obtaining all referrals and prescriptions needed for insurance coverage.
- I understand that I am responsible for understanding the benefits available to me under my personal insurance plans, including deductibles or co-pays.
- I will be personally responsible for all deductible or co-pay expenses.
- I will assume financial responsibility for any charges not covered by insurance.
- Medicare patients will be responsible for getting a new MD prescription every 90 days.
- I understand that **PT SUCCESS CLINIC** will not bill my attorney directly. I understand my claims will be submitted directly to the insurance carrier and I will provide the office with the appropriate information. **PT SUCCESS CLINIC** will forward copies of billing information to my attorney with my written request.
- I acknowledge my therapy is only effective with consistent attendance. Therefore, I understand I will be discharged after three (3) "No-Shows".

I have read and understand the above. If under 18, a parent or guardian must sign below.
Name:____ Date:_______________________________

Parent or Guardian:____