New Patient Form

Advantage Physical Therapy

Date ____________________

Patient Information

Patient's Name ____
Last Name | First Name | Middle Name | Name you go by

Street ____

City, State, Zip ______________________ Home Phone ______________ (include area code) Cell Phone ______________ (include area code)

Sex ______ Birth Date ______________ (mm/dd/yyyy) Age ____ SSN ______________ Driver's Lic. # ______________ Marital Status ______________

Patient's Employer ______________________ Occupation ______________________ Work Phone ______________ (include area code)

Spouse's Name ____
Last Name | First Name | Middle Name | Name goes by

Spouse's Employer ______________________ Occupation ______________________ Work Phone ______________ (include area code)

Emergency Contact

Contact's Name ______________________ Relationship ______________________ Phone ______________ (include area code)

Referring Provider

Referring Provider ____

Insurance Information

Insurance #1 ____

Group # ______________________ Contract # ______________________ Co-pay ______________

Name of Insured ______________________________________ Relationship to Patient ______________

Sex ______ Birth Date ______________ (mm/dd/yyyy) SSN ______________

Authorization to Release Information and Assignment of Benefits

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by insurance, as well as co-pays, deductibles, or non-covered services that may occur. I understand that I will be billed to my home or post office address for any balances outstanding.

I hereby authorize Advantage Physical Therapy to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to Advantage Physical Therapy or to the party who accepts assignment. I certify that the information I have reported with regard to my insurance coverage is correct.

Signature ____ Date ________________________