



**Patient Info**

IMPORTANT: Please fill out this form completely & legibly. (Do not leave any items blank.)

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender \_\_\_M\_\_\_F  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
 Home Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_  
 Emergency Contact Phone: ( ) \_\_\_\_\_ Emergency Contact Relationship \_\_\_\_\_  
 Referring MD: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_

**Insurance Info**

IMPORTANT: Please know your insurance benefits before attending

Primary Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Date of Eligibility: \_\_\_\_\_  
 Deductible: \$ \_\_\_\_\_ Amount of Deductible Met: \$ \_\_\_\_\_ Max out of pocket: \$ \_\_\_\_\_  
 Co-Pay: \$ \_\_\_\_\_ Co-Insurance: \_\_\_\_\_% In or Out of Network: \_\_\_\_\_  
 # PT visits allowed per year: \_\_\_\_\_ # visits seen this year: \_\_\_\_\_ Max reimbursement: \$ \_\_\_\_\_  
 Secondary Insurance Company: \_\_\_\_\_ ID #: \_\_\_\_\_  
 Policy Holder: \_\_\_\_\_ Date of Eligibility: \_\_\_\_\_  
 Deductible: \$ \_\_\_\_\_ Amount of Deductible Met: \$ \_\_\_\_\_ Max out of pocket: \$ \_\_\_\_\_  
 Co-Pay: \$ \_\_\_\_\_ Co-Insurance: \_\_\_\_\_% In or Out of Network: \_\_\_\_\_  
 # PT visits allowed per year: \_\_\_\_\_ # visits seen this year: \_\_\_\_\_ Max reimbursement: \$ \_\_\_\_\_  
 (Office use only) Verified By: \_\_\_\_\_ Date: \_\_\_\_\_

**CREDIT CARD INFO:** Credit Card Type: \_\_\_\_\_ Exp. Date: \_\_\_\_\_  
 Card # \_\_\_\_\_ CVC Code: \_\_\_\_\_

**This card will be charged for services rendered and/or for cancellations with less than 24-hour advance notice.**

I consent to be evaluated and treated and realize that I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize the release of information acquired in the course of my treatment, including but not limited to medical records, electronic and oral communications, to my insurance company representatives, employer, primary care physician, referring MD and/or other third party payer. **I authorize charges to my credit card above for services rendered or if I fail to give at least 24-hour advance notice prior to cancellation or reschedule of my appointments.**

Patient Signature Required: \_\_\_\_\_ Date: \_\_\_\_\_