Integrated Physical Therapy, LLC

Patient Information - All Patients Please Complete This Section

Name: _____	Date of Injury/Onset of Condition: _____
Address: _____	Date of Birth: _____ Age: _____
City/State/Zip: _____	Sex (please circle): Male Female
Home Phone: (_____) _____	Social Security #: _____ - _____ - _____
Work Phone: (_____) _____	Emergency Contact: _____
Cell Phone: (_____) _____	Telephone No: (_____) _____
Email: _____	

Physician Information

Referring Physician: _____	Telephone no: (_____) _____

Medical Insurance Information (is this incident related to an automobile accident YES NO please circle one)

Personal Insurance: _____	Automobile Insurance Co._____
Member ID No: _____	Policy No: _____
Group No: _____	Claim No: _____
Are you the primary on the account: YES NO	Adjuster: _____
If NO, relationship to insured: _____	Contact Tele No : (_____) _____ _____
Primary account holders name: _____	Date of accident: _____
Primary account holders date of birth:_____	

Attorney Information – Please Complete This Section if You Are Represented By an Attorney

Attorney Name: _____	Telephone No: (_____) _____
Address: _____	Floor/Suite No: _____
City/Sate/Zip: _____	

Employer Information –Please Complete This Section **ONLY** If Your Injury Occurred While You Were Working

Employer Name: _____	Claim/Group No: _____
Insurance Company Name: _____	Policy No: _____
Address: _____	Telephone No: (_____) _____
City/State/Zip: _____	Contact Person: (_____) _____

Authorization to Release Information – Assignment of Benefits – Agreement/Contract & Consent to Treatment

√	I hereby authorize Integrated Physical Therapy, LLC to release to my insurance company(s) & or my attorney named above any information acquired in the course of my examination or treatment.
√	I hereby agree to full responsibility for all expenses incurred by or on account of me (the patient), and hereby assign Integrated Physical Therapy, LLC any and all insurance &/or settlement benefits due to me (the patient) to the full extent of my financial obligation to this facility.
√	I understand my insurance coverage is a relationship between myself and my insurance company, and I agree to accept full financial responsibility for payment of charges incurred. I hereby consent/agree to be treated and cooperate as expected.

Your (patient) Signature: _____ Date: _____

(Parent or Guardian Must Sign If Patient Is Under 18)