

Patient Information – For patients under Age 18

Name _____ Address _____ _____ <small>City State Zip Code</small> Home Phone (____) _____ Onset of Symptoms/Injury Date ____/____/____ <small>(Either approximate or specific)</small> Your Email Address _____	Date of Birth ____/____/____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Cell Phone (____) _____ Parent Cell Phone (____) _____ Referring Physician _____ Parent Email Address _____
What Type of correspondence do you prefer? <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Call	

PRIMARY INSURANCE COVERAGE:

SECONDARY INSURANCE COVERAGE:

Insurance Company: _____ Member ID#: _____ Name of Insured (Policy Holder): _____ Insured Date of Birth: ____/____/____ Relationship to Insured: <input type="checkbox"/> Child <input type="checkbox"/> Other Insured Employer: _____ Insured Address: _____ _____ Insured Social Security #: _____	Insurance Company: _____ Member ID#: _____ Name of Insured (Policy Holder): _____ Insured Date of Birth: ____/____/____ Relationship to Insured: <input type="checkbox"/> Child <input type="checkbox"/> Other Insured Employer: _____ Insured Address: _____ _____ Insured Social Security #: _____
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IF YOU HAVE HAD AN ACCIDENT (Work or Auto), PLEASE COMPLETE THIS SECTION: It is our standard policy to collect your personal insurance information so we can coordinate payment and responsible party information.

Date of Accident _____	Type of Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other _____
Insurance Company (Worker's Comp./Auto Ins) _____	
Address _____	Phone _____
Claim Number _____	Adjuster _____
Name of Insured _____	
FOR AUTO ACCIDENTS: Is this a Lien? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Yes: Attorney Name: _____	Attorney Phone #: (____) _____

A complete and detailed physical evaluation is one of the most important tests to determine your condition and appropriate treatment. During this evaluation you will be asked to perform maneuvers. We would like you to be as cooperative as possible. However, if you know that a particular maneuver or activity will cause pain or significant injury, please do not attempt to perform that maneuver and let the therapist know at that time. Under no circumstances should you perform or submit to any part of the evaluation which might cause you significant pain.

Assignment of Benefits:

I understand that I am responsible for the payment of all services rendered regardless of insurance payment. I authorize payment of medical benefits to the named provider for professional services rendered.
Billing: I authorize Physical Therapy Partners Nevada to bill the Insurance companies/Worker's Compensation Insurance/Auto Insurance listed above for all services rendered.
Liens: I fully understand the terms and conditions of payment For my lien.

Release of Information:

I authorize the release of any medical information necessary to process this claim. I authorize the release of information from any medical provider for treatment and billing.

Notice of Privacy Practices:

I acknowledge that I have read and understand the Notice of Privacy Practices of Physical Therapy Partners located in our lobby.

Signed _____ **Date** _____