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| **Patient Information** |
| Name: Click here to enter text. | Date of Birth: Click here to enter text. |
| Address: Click here to enter text. | Sex: . |
| City ST Zip | Cell Phone: Click here to enter text. |
| City State Zip | Home Phone: Click here to enter text. |
| Social Security #: SS # | Work Phone: Click here to enter text. |
|  | Email Address: Click here to enter text. |
| Referring Physician: Click here to enter text. | Would you like to subscribe to our Newsletter?  |
| Onset of Symptoms/ Injury Date: Date |
| Marital Status:  |
| Are you seeing other healthcare providers/therapists?  If yes, who and where? Click here to enter text. |
| Which type of correspondence do you prefer?  |

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| --- | --- |
| **Primary Insurance Coverage** | **Secondary Insurance Coverage** |
| Insurance Company: Ins Co | Insurance Company: Ins Co |
| Member ID #: Click here to enter text. | Member ID #: Click here to enter text. |
| Name of Policy Holder: Name DOB:DOB | Name of Policy Holder: Name DOB: DOB |
| Relationship to Insured: . | Relationship to Insured: . |
| Insured Employer: Click here to enter text. | Insured Employer: Click here to enter text. |
| Insured Address:Click here to enter text. | Insured Address: Click here to enter text. |

**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 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 circumstance should you 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.

**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.

**Billing**: I authorize Physical Therapy Partners Nevada to bill the Insurance Companies/ Worker’s Compensation Insurance/ Auto Insurance listed above for all services rendered.

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

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| **Signed:** Sign | **Date:** Date |