

For office use only: P C Y  
Diagnosis \_\_\_\_\_  
ICD-9 \_\_\_\_\_

### Personal Information

Patient Name \_\_\_\_\_, \_\_\_\_\_ Today's Date \_\_\_\_\_  
(Last) (First) (middle)  
Date of Birth \_\_\_\_\_ Gender M/F Marital Status S M W D SS# \_\_\_\_\_  
Home / Billing Address \_\_\_\_\_ City \_\_\_\_\_ State CO Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Employer Name \_\_\_\_\_ Parent name (if patient is minor) \_\_\_\_\_

### Emergency Contact Information

In Case of an Emergency, Who May We Contact \_\_\_\_\_  
Relationship to Patient (please Circle) Spouse Daughter Son Parent Friend Other  
Emergency Contact Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

### Physician Information

Name of Referring physician \_\_\_\_\_ Dr. Phone # \_\_\_\_\_  
Name of Primary Care Physician (if different from above) \_\_\_\_\_

### Insurance Information

Type of Insurance (circle): Health Medicare Workers compensation Auto Self pay  
Health Insurance Name \_\_\_\_\_ Insurance Phone # \_\_\_\_\_  
Name of Insured \_\_\_\_\_ DOB of Insured \_\_\_\_\_  
Subscriber # \_\_\_\_\_ Group \_\_\_\_\_ SS# of Insured \_\_\_\_\_  
Secondary Insurance Name (if applicable) \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Secondary Insurance Phone \_\_\_\_\_ Group # \_\_\_\_\_  
If work comp: Work Comp Insurance: \_\_\_\_\_ Employer \_\_\_\_\_ Date of Accident \_\_\_\_\_  
Claim # \_\_\_\_\_ Adjustor Name \_\_\_\_\_ Adjustor phone # \_\_\_\_\_  
If auto accident (Please provide health insurance information also): Auto Insurance \_\_\_\_\_  
Date of Accident \_\_\_\_\_ Name of insured \_\_\_\_\_ Claim # \_\_\_\_\_  
Adjustor Name \_\_\_\_\_ Adjustor Phone # \_\_\_\_\_ Do you have Med Pay? Y / N  
If yes, what is the amount? \_\_\_\_\_ Attorney Name and # \_\_\_\_\_  
If other driver at fault: Insurance of Other Driver \_\_\_\_\_ Insurance Phone \_\_\_\_\_  
Adjustor Name \_\_\_\_\_ Name of Insured \_\_\_\_\_ Claim # \_\_\_\_\_

### **Authorization to release information:**

I hereby authorize FIT Physical Therapy, LLC to provide reasonable and proper medical care and to release to my insurance company and my physician any information acquired in the course of my examination or treatment. In addition, I hereby authorize payment of all benefits directly to FIT Physical Therapy, LLC for medical services rendered. I further understand any charges incurred not covered by my insurance are my responsibility. I agree to pay all collection costs and attorney fees. **Signature of Patient (or Guardian)** \_\_\_\_\_

If physical therapy to be covered by **out of network benefits**: I understand that I am receiving out of network service and there may be additional expenses incurred by me as a result.

**Signature of Patient (or Guardian)** \_\_\_\_\_