

For office use only: P C Y W
Diagnosis _____
ICD-9 _____

Personal Information

Patient Name _____, _____ Today's Date _____
(Last) (First) (MI)
Date of Birth _____ Gender M/F Marital Status S M W D SS# _____
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 workers comp or Auto: Employer _____ Date of Accident _____ Claim# _____
Adjustor Name _____ Adjustor phone # _____ Do you have Med Pay? Y / N
If yes, what is the amount? _____ Attorney Name and # _____

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) _____

Missed Appointments:

Unless canceled at least 24 hours in advance, our policy is to charge \$30.00 for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.

Signature of Patient (of Guardian) _____