

Patient Information

Marital Status: Single Married Divorced Wildowed Emergency Contact: Phone # Relationship Relationship Phone # Relationship Relationship Remity Octor(s) Are you currently under the care of a Home Health Agency? No Yes, name of Co. How did you hear about FYZICAL? Insurance Information Medicare # Part B effective date Insurance Policy # Group #: Policyholder's Name: Relation to Patient: DOB: Insurance Address (if other than above): "If Patient is a minor* Responsible party for bill if other than patient: Responsible party's address (if other than above): Date of Birth: Consent for Treatment: I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary or advisable by the physical therapist. Consent to Release Medical Information: I authorize FYZICAL to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and Consent to Obtain Medical Information: I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation. Assignment of Insurance Benefits: I hereby authorize payment to be made directly to FYZICAL. Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees,	Last Name:		First Name:		Middle Initial:
Date of Birth: Sex: Email: Home Phone #: Work Phone #: Cell #: Marital Status: Single Married Divorced Widowed Emergency Contact: Phone # Relationship Primary Care Physician / Family Doctor(s) Are you currently under the care of a Home Health Agency? No_Yes, name of Co. How did you hear about FYZICAL? Insurance Information Medicare # Part B effective date Insurance Policy # Group #: Policyholder's Name: Group #: Insurance Address (if other than above): "If Patient is a minor* Responsible party for bill if other than patient: Responsible party's address (if other than above): Date of Birth: Consent for Treatment: I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as is deemed necessary o advisable by the physical therapist. Consent to Release Medical Information: I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation. Assignment of Insurance Benefits: I hereby authorize payment to be made directly to FYZICAL. Guarantee of Payment: I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limitled to, late fees,					
Home Phone #:	City:		Sta	te: Zip:	
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Insurance Information Medicare #					
Insurance Information Medicare #	Are you currently under the c	are of a Home Healt	h Agency?No_	Yes, name of Co	
Medicare #	How did you hear about FYZ	ICAL?			
Insurance Policy #	Insurance Information				
Policyholder's Name:	Medicare #		Part B effective	ve date	
If Patient is a minor Responsible party for bill if other than patient:	Insurance Policy #		Gro	oup #:	
If Patient is a minor Responsible party for bill if other than patient:	Policyholder's Name:		Rela	tion to Patient:	DOB:
Responsible party for bill if other than patient:					
Responsible party's address (if other than above):	*If Patient is a minor*				
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		•			•
interest fees, legal fees, and collection agency fees.					
I hereby certify that I understand these rights as set forth.	I hereby certify that I under	stand these rights	as set forth.		
Patient/Responsible Party Signature:Date:				Date:	