NORTHSHORE FYZICAL THERAPY & BALANCE CENTERS

□ Cedarburg □ Thiensville

THERAPIST_____ DATE OF FIRST APPT_____ DATE OF RX_____

Last Name	**First Name**	**Mid. Initial**	**Date of Birth**
Address	**City**	**State**	**Zip**
Best Phone #	**Alternate Phone#**		**Social Security #**
Email	**Sex M / F**	**Minor Y / N**	**Marital Status S M W D**
Patient's Employer	**Address**	**City**	**State Zip Phone #**
If Patient is not the Policy Holder - Insured's Birthdate Employer Address City State Zip			
Emergency Contact	**Relationship**		**Phone #**
Reason for visit today: Accident □ Work Injury □ Other □ Please explain:			
If Accident related – Attorney Name/Address			
Date of onset of symptoms:			
Have you had therapy anywhere else this year? Yes/No if Yes, where? **Have you received home health services during the last 3 months? Yes/No**			

FOR OFFICE USE ONLY

Primary Insurance Company	Secondary Insurance Company
ID# Group#	ID# Group#
Address	Address
Name of Policy Holder	Name of Policy Holder
Policy Holder's Date of Birth	Policy Holder's Date of Birth
Diagnosis: ICD-9/10 Codes 1. 2. 3. 4.	Referring MD: Address Phone # Fax# NPI#

PROFESSIONAL FEES: Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary, average, median, etc. In some cases an insurance company will pay the entire fee, while in other cases an insurance company will pay only a portion of the fee. We will furnish a reasonable number of medical and insurance reports to expedite your insurance claim.

FINANCIAL AGREEMENT: I hereby authorize payment of medical insurance benefits due to me or my dependent to be made directly to **Northshore FYZICAL Therapy & Balance Centers**. I understand that I am responsible for that portion of fees not paid by insurance. Credit card payments are accepted. Should the account be referred to an attorney or agency for collection, I will be responsible for reasonable attorney's fees and collection expenses.

CANCELLATION POLICY: Northshore FYZICAL Therapy & Balance Centers enforces a 24-hour cancellation policy. For each appointment missed without proper notice, a $25 fee will be charged. I am aware that Northshore FYZICAL Therapy & Balance Centers requires at least a 24-hour notice for any appointment that must be cancelled or missed.
I will be responsible for the $25 fee charged for cancellation without proper notice.

RELEASE OF INFORMATION: I authorize Northshore FYZICAL Therapy & Balance Centers to furnish insurance companies or their representatives, physicians, or other parties as indicated information concerning my (my dependent's) illness, injury, and/or treatment necessary for completion of claims for insurance benefits.

_____ _____

Signature Date

Are you interested in receiving information on upcoming seminars and special events associated with the clinic?
□Yes □ No Which method do you prefer: □ Standard Mail □ Email

Please take a moment to let us know how you found out about Northshore FYZICAL Therapy & Balance Centers and our services? If you found us through a newspaper or yellow pages directory, please identify the publication. If you found us through the internet, please identify the search engine/website. Thank you.

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