FYZICAL Therapy & Balance Centers

Personal Information

Patient Name_____ , _____ ____ **Today's Date**_____
(Last) *(First)* *(MI)*

Date of Birth_____ **Gender** *M / F* **Marital Status** *S M W D*

Address _____ **City**_____ **State** *CO* **Zip** _____

Home Phone_____ **Work Phone**_____ **Cell phone**_____

Email _____ **May we contact you by email?**_____

May we leave confidential information on voicemails for numbers listed above? _____

Employer Name_____ **Parent name (if patient is minor)**_____

Emergency Contact Information

In Case of an Emergency, who may we contact?_____ **Relationship?**_____

Emergency Contact Phone _____ **Work**_____ **Cell**_____

May we discuss your care, schedule and billing information with the person listed above? _____

Referring Physician Information

Name of Referring physician _____ **Dr. Phone #**_____

Name of Primary Care Physician (if different from above) _____

Insurance Information or Present Insurance Card

Health Insurance Name **PLEASE PRESENT CARD** **Insurance Phone #** _____

Name of Insured _____ **DOB of Insured** _____

ID#_____ **Group** _____ **SS# of Insured** _____

Secondary Insurance Name (if applicable)_____ **ID #** _____

Secondary Insurance Phone_____ **Group #**_____

Is your condition due to an accident: Y / N **Type of Accident**: Auto/Work/Other **Date of Accident**_____

Claim# _____ **Adjustor Name** _____ **Adjustor phone #** _____

Do you have med pay on your auto policy? Y / N **If yes, what is the amount**?_____

Attorney name and number _____

Authorization to release information:

I hereby authorize Fyzical Therapy & Balance Centers to release information to my insurance company, my physician and any other pertinent medical provider any information acquired in the course of my treatment. In addition, I hereby authorize payment of all benefits directly to Fyzical Therapy & Balance Centers 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 benefit are out of network: I understand there may be additional expenses incurred by me as a result. **Signature of Patient (or Guardian)** _____

Missed Appointments:

Unless cancelled at least 24 hours in advance, our policy is to charge $50.00 for missed appointments. Please help us serve all of our patients better by giving us 24 hours notice for cancelled appointment. Please let us know if you have any questions or concerns.

Signature of Patient (or Guardian)_____