PATIENT INFORMATION FORM

Social Security #	First Name	MI	Last Name	Sex M/F	DOB / /
Home Telephone # ( )	Best Contact Telephone # ( )	E-mail Address		Marital Status	
Address (Street)		PO Box	City	State	Zip Code
Emergency Contact Name	Emergency Contact Phone # ( )	Relationship to Patient			
Current Employer	Employer Telephone # ( )	Employer Address			
Policy Holder's Name	Policy Holder's DOB / /	Policy Holder's Employer			
Have you received services from a home health agency within the last 30 days? YES NO	Have you received any outpatient physical therapy this year? YES NO	Current Work Status (Circle One) Full Part Student Retired			

PAYMENT AND INSURANCE FILING

Payment is requested at the time of service unless other arrangements are made prior to treatment. Payment may include a co-pay or estimated patient balance depending on your insurance type. Payment can be made by cash, check, MasterCard or Visa. We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Intown PT. The above does not apply for those patients that are considered Workers' Compensation; however, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Initial _____

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Intown PT cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we require that the full charge be paid at the time of treatment unless prior arrangements have been made and documented.

CONSENT FOR TREATMENT AND AUTHORIZATION

I do hereby consent for treatment at Intown Physical Therapy. I authorize Intown PT to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to Intown Physical Therapy, LLC when indicated on claim. I understand I am financially responsible for the services I received.

Signed:_____ Date:_____

Relationship to Patient (self/parent/guardian) :_____

Witnessed by:_____