ALLIANCE
PHYSICAL THERAPY

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Date_____

PATIENT INFORMATION

Name: _____Date of Birth: _____Age: _____

Street Address: _____City: _____State: _____Zip Code: _____

Home Phone: _____ Sex: ( )Male ( )Female SSN#:_____

Marital Status: ( )Single ( )Married Work Status: ( )Employed ( )Employed PT ( )Student

Name of Spouse or Parent (if child): _____

***Please note** when completing information below if patient is a child please provide parent or guardian information :

Employed by: _____ Business Phone: _____

Address: _____ Supervisor:_____

_____

EMERGENCY CONTACT:

Name: _____ Phone: _____

INSURANCE INFORMATION

(Circle one) Private Workers Comp No-Fault

Primary Insurance: _____ Billing Address: _____

Secondary Insurance:_____

Name of Policyholder: _____ Date of Birth: _____

SS #:_____ Insurance Phone#: _____

Policy, Carrier Case or ID#: _____ Plan#: _____ Group#/WCB File#: _____

Referring Physician: _____Primary Care Physician: _____

Date of Original Injury: _____ Date of Surgery: _____ Date of Current Injury: _____

Attorney(if any): _____Phone#: _____

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION STATEMENTS

I hereby authorize **Alliance Physical Therapy** to release any medical information to my insurance company to process my insurance claim.

* I understand that I am financially responsible for all charges not paid for by the insurance including any and all co-payments, co-insurance and deductibles.
* I further agree to pay all collections costs, attorney fees and other collections costs that may be incurred to enforce the collection of any outstanding balance due.
* I understand that it is my responsibility to inform **Alliance Physical Therapy** of any changes in the information on this form.

I assign to Alliance Physical Therapy sufficient monies and benefits to which I may be entitled from the governmental agencies, insurance carriers or others who are financially liable for my medical care, to cover the costs of the care and treatment to me or my dependent.

Patient's Signature: _____ Date: _____

If signed by a representative please print name and relationship to patient below:

Print Name: _____ Relationship: _____