Witte PHYSICAL THERAPY

DEMOGRAPHICS

Date: _____ Birthdate: ___ / ___ / ___ Age: ____

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Male: ____ Female: ____

Marital Status: Single Married Divorced Widowed Student

Home Phone: _____ Cell: _____ Work: _____

Email Address (appointment reminders, billing statements): _____

Employer: _____ Occupation: _____

Physician Referred By: _____ How Did You Hear About us: _____

In Case of Emergency Contact: _____ Relationship: _____

In Case of Emergency Phone Number: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____

Policy Holder Name: _____ Policy Holder DOB: __ / __ / ____

Secondary Insurance Carrier: _____

Policy Holder Name: _____ Policy Holder DOB: __ / __ / ____

IF UNDER THE AGE OF 19 PLEASE COMPLETE THE FOLLOWING:

Mother's Name: _____

Home Phone: _____ Cell: _____ Work: _____

Father's Name: _____

Home Phone: _____ Cell: _____ Work: _____

AUTHORIZATION AND RELEASE

I certify that the information provided above is true and correct to the best of my knowledge and belief.

I authorize this clinic to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period such care to third party payors and/or health care providers. I authorize and request my insurance company to pay directly to the physical therapist's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance, and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances. A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third parties used for treatment, billing, collection, and other services may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers may leave messages for me manually and be using automated systems such as by artificial or prerecorded voice. Specifically, if I proved a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from an of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.

Signature of Patient/Guarantor: _____