Witte PHYSICAL THERAPY

DEMOGRAPHICS

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

Last Name: _____ First Name: _____MI: _____

Address: _____ City: _____

State: _____ Zip Code: _____ SSN: _____

Marital Status: Single Married Divorced Widowed Student

Home Phone: _____ Cell: _____ Work: _____

Email Address (appointment reminders, billing statements):
_____

Employer: _____Occupation: _____

Employer Address: _____ City: _____ Zip: _____

Physician Referred By: _____

Spouse, Parent, or In Case of Emergency Contact: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Employer: _____Occupation: _____

Employer Address: _____ City: _____ Zip: _____

SSN: _____ Email: _____

Relationship to Patient: _____ In Case of Emergency Phone Number: _____

INSURANCE INFORMATION

Name of Insured (Policy Holder): _____Relationship to Patient:_____

Policy Holder DOB: _____ Policy Holder SSN: _____

Do you have secondary insurance coverage? Y or N, if yes then complete the following:

Name of Insured (Policy Holder): _____Relationship to Patient:_____

Policy Holder DOB: _____ Policy Holder SSN: _____

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 company 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 understand and agree that I am ultimately responsible for any unpaid balances. I understand and agree that any cellular or land line phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as means to contact me, and that this office and our service providers may leave messages for my manually and by using automatic systems such as by artificial or prerecorded voice. 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. 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. 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. 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:

_____