PATIENT INFORMATION

Patient Name: ___________________________________
Address: ____
City: ____________________ State: _____ Zip Code: ________
Home Telephone #: _____________________ E-Mail Address:___________________
Date of Birth: ________________________
Social Security Number: _______-______-__________

MARITAL STATUS: M S D W (Circle one)
Spouse's Name: ________________Patient's Employer: ______________________
Address:________________________________
City: ____________________ State: ___Zip Code: ______
Work Telephone #: _____________________
Name of (Primary) Physician: ________________________
Telephone #: _____________________
In case of emergency, who do we contact? _________________________
Telephone #: __________________ Cell Phone #: ____________________
Relationship: __________________
Whom may we thank for referring you to us? ___________________

I, _______________________(please print clearly—if minor, parent or guardian signature) consent to evaluation and treatment by Anchor Physical Therapy, LLC., of my problem as diagnosed by my physician.

Please complete the following only if subscriber is not the patient or a minor:

Subscriber Name:_________________________ Date of Birth: ___________________
Employer: _________________________________
Employer Telephone: ___________________
Employer Address: _________________________
City: ______________ State: ___ Zip Code: ________

What are you here to be treated for:____
Are services related to a work or auto injury:
(circle one if applicable) WORK AUTO Date of Injury: ____________
Claim Number: ___________________
Insurance Carrier: _______________________Telephone: _________________
Address:_________________________
Claim Representative: _____________________City: _________________
State: ___Zip: ______ Representative Phone: _____________________

ASSIGNMENT OF BENEFITS:
I hereby assign all medical benefits, to include major medical health benefits to which I am entitled, including Medicare, private insurance and any other health plan to Anchor Physical Therapy, LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. If I receive direct payment from my insurance company for my physical therapy treatment, I will be responsible to bring this payment to Anchor Physical Therapy LLC, to be applied to my account for services rendered. I certify this information is true and correct to the best of my knowledge.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS: Anchor Physical Therapy, LLC. is authorized to provide and request from my referring physician, other physicians and/or my attorney, information regarding my diagnosis and medical condition for physical therapy while under their treatment. Information to be disclosed may include nature of the physical impairment, history, contributing factors, subjective symptoms, diagnosis, prognosis and other information pertinent to my treatment. Photostatic copy of this authorization shall serve in its stead.

Date: ____________________________ Signature: _______________________________