Advantage Sports Medicine and Physical Therapy

Name:		Sex: Male or Female
Address:		Date of Birth:
City/State/Zip:		Age:
Employer:		Home Phone:
Employer Address:		Work Phone:
City / State / Zip:		Cell Phone:
		Email:
Responsible Person (if minor):		Social Security Number:
Responsible Person Telephone:		Occupation:
Address (if different):		Have you had physical therapy before? Yes No
		If so, when?
Referring Doctor:		
Primary Care Doctor:		Is your injury a result of a motor vehicle accident?
Primary Care Doctor’s Phone:		Yes No
Did you call your PCP for a referral? Yes No		Is your injury a result of an injury at work?
What do you need to be seen for today?		Yes No
Diagnosis:		
Health Insurance Company Name:		
Policy or ID Number: (Please leave card out for us to copy)		
Name of Subscriber to Insurance Policy:		
Relationship to subscriber (Self, spouse, child,etc.):		
Subscriber’s Employer:		
How much is your copay for each physical therapy office visit:		
$5 $10 $15 $20 or if a percentage, how much?:		

Assignment & Release: I authorize my insurance benefits to be paid directly to the provider. I acknowledge that I am financially responsible for any unpaid balance should I exceed the benefit limit or do not obtain the appropriate referral or authorization for treatment. I understand I may be charged additional fees for court fees and other collection costs if I default in paying any balance on my account. I authorize the release of any information required by the above insurance company. I understand and give my consent to the treatment plan my physical therapist has recommended for my injury.

Signature:		**Date:**