ALTITUDE PHYSICAL THERAPY

PATIENT INFO: **Date:** _____

Name: _____ Sex: M or F

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Date of Birth: _____ SSN: _____

Emergency Contact: _____ Phone: _____

Email address: _____ **Preferred method of contact:** • Phone • Email • Text

How did you hear about us? (check all that apply) • Doctor • Past Patient • Facebook or other Ad • Other

Have you attended one of our workshops? • Yes • No **If Yes, which one**: _____

Referring MD: _____ Date of last MD visit**:** _____

Is this due to an auto accident or worker's comp injury? • Yes • No Date of Injury: _____

• Auto • Worker's Comp Claim Number: _____

Employer: _____ Phone: _____

GUARANTOR INFO: (Responsible party for children under the age of 18)

Name: _____

Policy Holder's SSN: _____ Date of Birth: _____

INSURANCE ASSIGNMENT AND PATIENT FINANCIAL RESPONSIBILITY:

***As a courtesy, Altitude Physical Therapy will verify your insurance benefits However, as the patient/guarantor, you are responsible for any co-pays or balance on your account. If services are not covered, benefits exhausted, or insurance denies your claims, you will be billed directly for all services rendered.* **Initial** _____

_____

Patient/Guarantor Signature Date