# USA PHYSICAL THERAPY
## PATIENT INFORMATION

Name:_______________________________________________ DOB:__________________ Gender:________

Social Security #:_________________________ Email:_______________________________________________

Address:______________________________________________________________________________________

City:___________________________________ State:__________ Zip:___________________________________

Home Phone:______________________ Cell Phone: _____________________ Work Phone:_________________

Employer Name:__________________________________ Occupation:___________________________________

In Case of Emergency, list two people we may contact:

Name:___________________________________ Phone:_______________________ Relationship:____________

Name:___________________________________ Phone:_______________________ Relationship:____________

## INSURED INFORMATION

Same as above? Y or N (Circle One) If different from above, please complete below

Name:_________________________________________________________________________________________

Social Security #:___________________________ DOB:_______________________ Gender:________________

Address:______________________________________________________________________________________

Home Phone:_____________________ Cell Phone:______________________ Work Phone:__________________

Patient's Relationship to Insured: Spouse Son Daughter Other__________________

## HEALTH INFORMATION

Referring Doctor:__________________________ Diagnosis/Injury being seen for___________________________

How did you hear about us? (Doctor, website, friend, etc.)_______________________________________________

Date of Injury:____________________________ How were you injured? At Work Sports Car Accident Other

Please Specify:__________________________________________________________________________________

Please list any health issues we should be aware of (heart problems, epilepsy, diabetes, pregnancy, current meds, etc)

______________________________________________________________________________________________

I hereby assign to USA Physical Therapy all money to which I am entitled for medical expenses relative to the services provided by USA Physical Therapy. If benefits are not assignable, I agree to pay for these within five days of receipt of the settlement proceeds of the liability claim. In the event that payment is made directly to me, I agree that I will become personally liable for all charges. I understand that I am financially responsible for charges not covered by my insurance company. If USA Physical Therapy should have to retain an attorney to collect said sums, I understand that I will be responsible for any and all attorney fees and collection costs incurred. I authorize release of all records pertaining to my treatment to my insurance company, other third parties, or attorneys for payment of my medical charges.

We reserve the right to charge $25 for any missed appointments not cancelled 24 hours prior to your appointment time.

Patient/Legal Guardian's Signature:_____________________________________ Date:__________________