
## Patient Information (please print clearly)

Patient Name (full):_____Date:_____

Address:_____City:_____State:_____Zip:_____

Home phone:_____Work phone:_____Other phone:_____

Birth date:_____Sex: M F Marital Status:_____

Social Security #:_____Occupation:_____

Employer:_____Employer Address:_____

Email Address for Sending Home Programs:_____

Who referred you to physical therapy?_____Phone:_____

Primary Care Physician:_____Phone:_____

## Financially Responsible Person

Insured:_____Relationship:_____

Address:_____City:_____State:_____Zip:_____

Home phone:_____Work phone:_____Other phone:_____

Birth date:_____Sex: M F Marital Status:_____

Social Security #:_____Occupation:_____

Employer:_____Employer Address:_____

Other person to notify in case of emergency:_____Phone:_____

**Medical Insurance Coverage: If you wish to have us to bill your insurance directly, please present your card(s) and driver's license at your first visit. Also, please read and sign below.**

**Assignment of Benefits and Release of Medical Information:** I hereby authorize payment of medical benefits to SIMPLY RESULTS PHYSICAL THERAPY for services rendered to my dependents or myself. I also authorize the release of any medical information that is necessary to process Medicare and/or insurance claims. I understand that I am responsible for any amount not covered by insurance within 60 days of service, and finance charges/fees will be assessed on overdue balances. I understand that a copy or facsimile of this authorization can be used in place of the original. This assignment will remain in effect until revoked by me in writing.

Patient/Insured Signature:_____Date:_____