

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male Female Patient Social Security: \_\_\_\_\_

Marital Status: (Circle One) Married Single Divorced Separated Widowed

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Responsible Party/Insured Party Information** (Please fill out completely if other than Self)

Responsible Party: **Self** Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Responsible/Insured Party's Employer: \_\_\_\_\_

**Patient Employment Information**

Employment Status: (Circle One) Full Time Part Time Not Employed Retired Student

Patient's Employer/School: \_\_\_\_\_

**Insurance Information**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Group #: \_\_\_\_\_

*If the primary policy holder of your insurance is anyone other than yourself, please fill out Responsible Party/Insured Party Information above*

**PATIENT INFORMATION, continued...**

What are we seeing you for today? \_\_\_\_\_ Date of Illness/Injury: \_\_\_\_\_

May our office leave messages on your voice mail or answering machine regarding your healthcare, including but not limited to appointments, or other necessary treatment information at the stated numbers on this form. YES \_\_\_\_\_ NO \_\_\_\_\_

May our office leave messages with family members, friends, or other individuals that answer at the listed numbers on this form? YES \_\_\_\_\_ NO \_\_\_\_\_

**Authorization to Release Information:** I hereby authorize AZ SPORTSCENTER Physical Therapy & Conditioning, INC to release any information required in the course of my examination or treatment to the stated insurance companies.

Signed (Patient or Parent, if Minor): \_\_\_\_\_ Date: \_\_\_\_\_

**Authorization to Pay:** I hereby authorize payment directly to the business office of AZ SPORTSCENTER Physical Therapy & Conditioning, INC for medical benefits, if any, otherwise payable to me for services. I understand I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or Parent, if Minor): \_\_\_\_\_ Date: \_\_\_\_\_

*In order to control the cost of billing, AZ SPORTSCENTER Physical Therapy & Conditioning, INC requests payment of all co-pays at the time of service.*

\_\_\_\_\_ (Initial if applicable) If you are **Self-Pay**, please pay the balance in full at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collections.

**Workman's Compensation, if applicable**

Insurance Carrier: \_\_\_\_\_ Claim#: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_

Nurse Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_ (Initial) We will bill your Worker's Compensation Carrier for your charges. Please note you will remain financially responsible for any and all charges should your carrier deny coverage or your claim is contested.