

Physical Therapy Masters, LLC
Patient Health Information

BOX 1: PATIENT INFO. PLEASE PRINT AND WRITE LEGIBLY. COMPLETE ALL FIELDS.

Name LAST: _____ FIRST: _____ Middle Initial: _____
Address: STREET: _____ CITY: _____ STATE _____ ZIP: _____
Phone:(_____) _____ Date of birth _____ Sex: Male or Female
Marital Status: Single Married Divorced Other Social Security Number: _____
Patient's Employment Status: Full Time or Part Time STUDENT: Part Time Full Time none
Employer's Name _____ Cell Phone: _____
Is patient's condition related to: **Employment?** YES NO **Auto Accident?** YES NO **Other Accident** YES NO
In case of emergency please contact: _____ Phone: (_____) _____
What is the name of the doctor who referred you to Physical Therapy? _____
Name of PRIMARY INSURANCE: _____
MEMBER ID NUMBER: _____ **Insurance Group Number:** _____
Name of SECONDARY INSURANCE: _____
MEMBER ID NUMBER: _____ **Insurance Group Number:** _____
Name of TERTIARY INSURANCE: _____
MEMBER ID NUMBER: _____ **Insurance Group Number:** _____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

I authorize the release of any medical or other information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignments.

Signature of Patient: _____ Date: _____

Insured's OR Authorized Person's Signature: _____ Date: _____

I authorize payment of medical benefits to the undersigned physician or supplier for services described below, AND
I understand and agree that regardless of my insurance status, I am responsible for the balance of my account for any professional services rendered. I have read all of the information given. I certify that the information given is true and correct to the best of my knowledge. I will notify you of any change in my status or in the above information.

Signature of INSURED PERSON: _____ Date: _____

Signature of responsible party: _____ Date: _____

Therapist Provider's Name: _____

Signature of Provider: _____ Date: _____