Aaron D. Anders Physical Therapy

Patient Information

First Name: Middle: Last:

Street Address:

City: State: Zip:

Primary Phone #: ( ) - Secondary Phone #: ( ) -

SSN: - Gender: Male Female
DOB: / /

Employer: Occupation:

Referring Physician: Marital Status:

Primary Care Physician:

Responsible Party

☐ Check if same as above

Name: Date of birth:

Relationship to Patient: SSN:

Street Address: Telephone #: ( ) -

City: State: Zip:

Emergency Contact Information

Name: Relationship:

Address: Phone #: ( ) -

Is this injury related to a motor vehicle accident? **YES** **NO**

Is this injury a work related accident? **YES** **NO**

Primary Insurance: Secondary Insurance:

Group/Claim #: Group/Claim #:

ID #: ID #:

Subscriber Name: Subscriber Name:

Subscriber DOB: Subscriber DOB: / /

Consent to Physical Therapy Treatment/Authorization to pay/Release information:
I authorize Aaron D. Anders Physical Therapy, Inc. to make inquires as it determines necessary to confirm my coverage and financial responsibility. I authorize payers and/or reference to release such information to Aaron D. Anders Physical Therapy, Inc. I further understand that in signing as a patient or agent, I obligate myself to pay for services rendered. I agree to pay for services denied or not covered by my insurance regardless of the reason for non-payment. A photocopy of this document is to be considered as valid as an original. I hereby assign Aaron D. Anders Physical Therapy, Inc. All payments to which I am entitled for expenses related to services performed and direct payment for such services be made to Aaron D. Anders Physical Therapy, Inc.
I have been given the Notice of Patients Rights and I consent to physical therapy treatment.

Signature: Date:

Signature of Parent/Guardian: Date: