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: __________