PATIENT INFORMATION:

Patient's Name: _____ Birth date: _____
SSN: _____Street Address: _____ City/State/Zip: _____
Home Phone: _____ Cell/Business Phone: _____ Occupation: _____
Email address: _____ *Appt Reminder via*: € *Text* (Provider) _____
Verizon, AT&T, T-Mobile, Etc.
Employer: _____ Address: _____ € *Email* _____
(Email Address – if different than previous)
Spouse/Parent's Name: _____ Phone: _____
Employer: _____ Address: _____
Any Health Problems We Should Know About? _____

EMERGENCY CONTACT:

Name: _____ Relationship:_____
Home Phone: _____ Work Phone: _____ Cell Phone:_____

PRIVATE INSURANCE INFORMATION:

Primary Insurance Company: _____ Policy #: _____
Effective Date:_____ Insurance Company Phone: _____
Insured's Name: _____Relation:_____ DOB:_____

Secondary Insurance Company: _____ Policy #: _____
Effective Date:_____ Insurance Company Phone: _____
Insured's Name: _____Relation:_____ DOB:_____

MEDICARE/MEDICAID INFORMATION:

Medicare # _____or Medicaid # _____
Supplemental Insurance Company Name:_____
Policy #: _____ Insured's Name: _____ DOB:_____

INDUSTRIAL INSURANCE INFORMATION (WORKERS COMP):

Date of Injury: _____ Type of Injury: _____
Employer at Time of Injury: _____ Claim # _____

AUTHORIZATION AND RELEASE:

I authorize release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during period of such care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly the doctor or doctor's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services or that they may deem some services not medically covered. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In the case of default, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances. I understand that Rigby Physical Therapy reserves the right to bill me a ***$25.00*** *fee associated with no shows and/or cancellations of my scheduled appointment. I understand that I must inform Rigby Physical Therapy with at least a 24 hour notice if I become aware of any circumstances that would impede me from arriving at my scheduled time. By signing below I also acknowledge that I have been informed of the privacy and clinic practices.*

X _____ Date: _____
Signature of Patient or Parent/Legal Guardian of Minor