Ellis Physical Therapy

Please Print **Patient Information**			
Last Name:	First:	Middle Initial:	Soc Sec #
Address:	City:	State:	Zip:
Home Phone #	Cell Phone #	Returning Patient? Yes No	
Date of Birth: Age:	Single Married	Male Female	
Referring Doctor:	Patient E-Mail Address:		
Patient Employed by:	Work Phone #	Occupation:	
Is this accident related? Yes No Accident date:	Accident is Related to: Work Auto Other (If Other, please specify)		
In Case of Emergency Contact:	Phone #	Relation:	

Person Responsible for Account			
Person Responsible for Account (if different from patient)			Relation:
Address:	City:	State:	Zip:
Date of Birth: Soc Sec #	Home #	Cell #	
Employer:	Work Phone #	Occupation:	

Insurance Information		
Insurance Name:	Group #	Policy # Claim #
Insurance Address:	Insurance Phone #	
Policy Holders Name:	Date of Birth:	Relation:
Second Insurance Name:	Group #	Policy #
Insurance Address:	Insurance Phone #	
Policy Holders Name:	Date of Birth:	Relation:

Consent

I consent to receive physical therapy services. I understand medical information about me will be disclosed to health care professionals, and my insurance company(s) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operation at Ellis Physical Therapy. I authorize assignment of benefits to Ellis Physical Therapy. I understand that I am responsible for my payment amount as stated on the Explanation of Benefits . If your payment is not received within 90 days, I agree to pay any collection, rebilling or attorney fees as well as all interest accrued at 1.5% per month due to delinquency. I have read and understand the above statement and confirm this with my signature.

_____ _____

Patient Signature (Parent or Legal Guardian if under 18) Date: