

Welcome

Thank you for selecting our healthcare team! PRECISION PHYSICAL THERAPY Inc., is committed to excellence in serving the health needs of the community. We are dedicated to giving each Patient a personal service that they can rely on and trust. To help us meet your needs please fill out this form completely. If you have any questions or need help, please ask- we will be happy to assist you.

Patient Information

Name: Last _____ First _____ MI _____ Date _____

Current address _____

City _____ State _____ Zip _____

Phone #: H _____ W _____ ext _____ C _____

Male _____ Female _____ Date of Birth: _____

Social Security Number _____ (strictly used for billing purposes)

Permanent address _____ Phone _____

City _____ State _____ Zip _____

Employer _____ Occupation _____

Employer address _____

City _____ State _____ Zip _____

How did you hear about us?

Doctor _____ Friend _____

Insurance _____ Other _____

Insurance Policy Holder's Information:

Who is responsible for the account?

Name: Last _____ First _____ MI _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ (strictly used for billing purposes)

Male _____ Female _____ Date of Birth: _____

Home phone _____ Cell Phone _____

Work phone _____ ext _____

Consent for care and treatment: Your physical therapist will complete an evaluation process via interview and examination. From these findings, a treatment plan will then be designed. A treatment plan will be designed, utilizing a variety of treatment techniques. I, the undersigned, do hereby agree and give consent for Precision Physical Therapy, Inc. to provide physical therapy care and treatment identified as proper and necessary in addressing my physical condition.

Assignment of Benefits: I hereby assign payment directly to **Precision Physical Therapy, Inc.** who represents this clinic to Payor Groups. The basic benefits as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this treatment period. I understand I am financially responsible for any charges not covered by this assignment. I understand I will be held responsible for any costs incurred regarding collection of payment for services rendered.

Signature _____ Date _____

(Parent/Guardian's signature if patient is a minor)