



# PATIENT INFORMATION

Initial Appointment Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address \_\_\_\_\_ Injury Date: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Referring Dr: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Notes: \_\_\_\_\_

**PATIENT INFORMATION CONSENT FORM:** I have read and fully understand Aspen Physical Therapy's Notice of Information Practices. I understand that Aspen Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that ASPEN will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Aspen Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

INITIAL \_\_\_\_\_

**Authorization of Benefits and to Release Information:** I hereby authorize insurance payment to Aspen Physical Therapy and the release of any information to my insurance company acquired in the course of examination of treatment

INITIAL \_\_\_\_\_

**Treatment Authorization:** I hereby Authorize treatment of the above named patient and agree to accept responsibility for any changes incurred by services rendered through Aspen Physical Therapy.

INITIAL \_\_\_\_\_

**Insurance and Payment Policy:** Payment for our office services is required (I.E. copays, deductibles, etc.). We will file insurance for treatments and allow 60 days for the company to pay these claims. Thereafter, the payment on the account is due. If my account should become delinquent I will be responsible for the collection administration fee up to 35% of total charges.

INITIAL \_\_\_\_\_

Patient / Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

(If Patient is Under 18 Parent / Guardian Must Sign Form)