ALLIANCE PHYSICAL THERAPY

I hereby consent to treatment and authorize this medical service provider to furnish my insurance companies, including Medicare, with all information requested relating to my illness or injury. I authorize payment to be made to this medical service provider by commercial or government insurance for treatment and supplies provided, not to exceed my indebtedness.
I understand that I am financially responsible to this medical service provider for all expenses incurred and that my insurance carrier may apply amounts to deductible, copays, and/or coinsurance, for which I will be billed and must pay to this medical service provide. If there is a question regarding payment or denial of any claims, I understand that I must contact my insurance representative for clarification. I further understand that if there has been no payment toward my account in excess of 60 days, I may be levied interest and/or late fees at the current rate allowed by law.
With exercise comes the risk of possible injury. By signing this form you acknowledge that Alliance Physical Therapy is not responsible for any injury that may happen due to exercise throughout treatment in this facility.

A cancellation fee of $50 may be applied with less than 24 hour notice or without notice.

Patient Intake

Patient Name

Address

Reason for Visit:

Date of Injury:

Injury due to:
( )MVA ( )Workman's Comp
( )Surgery ( )Chronic ( )Other

( ) Single ( ) Married ( ) Divorced ( ) Widowed

Emergency Contact:

Relationship:

Phone:

Patient's Employer:

Employer Phone:

Employer Address:

Referring Physician:

Phone Number:

Date of Birth:

Height:

Weight:

Are you taking any medications?
( ) Yes ( ) No
Have you had Physical Therapy this year?
( ) Yes ( ) No

Phone:

( ) Cell ( ) Home ( ) Work

Phone:

( ) Cell ( ) Home ( ) Work

Email:

Would you like to receive appointment reminders?
( ) Text ( ) Email ( ) Phone Call

If patient is not primary on insurance, include spouse or parent name and date of birth:

Please complete the following if this is a motor vehicle accident (MVA) or Workers Compensation claim. We must have the claim number.

Claim Number:

Company:

Adjustor:

Phone Number:

Signature:_____ Date:_____

If you are taking any medications please list them on the back of this page