Progressive Physical Therapy

Patient Information and Consent

Claim Type (check one): ☐ Workers' Compensation ☐ Health Insurance ☐ Self-Pay ☐ Personal Injury/Attorney

Patient Information

Name (First, Middle, Last)	Birth Date	Age	Social Security #	Birth Gender ☐ M ☐ F
Mailing Address	City, State ZIP			
Email Address	Primary Phone ☐ Home ☐ Cell		Okay to leave message? ☐ Yes ☐ No	

How did you hear about us? ☐ Radio ☐ TV ☐ Friend ☐ Referral ☐ Internet ☐ Sign ☐ Other _____

Emergency Contact Name	Phone Number	Relationship to Patient
Name of Person Responsible for Payment (First, Middle, Last)	Social Security #	Date of Birth

Type of Injury	Date of Injury

Employment Information

Has a claim been filed to the workers' compensation carrier? ☐ Yes ☐ No

Employer/Company Name	Occupation	Employment Status
Employer Address	Employer Contact Name	Phone Number

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Patient Consent for Treatment

By my signature below, I hereby authorize the release of medical information needed to process my claim through my insurance company. I authorize my insurance benefits to be paid directly to Progressive Therapy Services and agree that I am financially responsible for any amounts not covered and/or paid by them. It is the policy of this office to collect charges for services as they are rendered, unless prior arrangements are made and credit is established. Insurance patients are responsible for paying their co-payments and deductible at the time services are rendered.

I hereby authorize such treatment as is necessary and to perform medical treatment on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above authorization for treatment, the reason the above named treatment is considered necessary the advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained to me. I also certify that no guarantee or assurance had been made as to the results that may be obtained.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No Initial _____

X _____

Patient or Authorized Person's Signature Date