ELEMENT PHYSICAL THERAPY
We are the balance experts

Date: _____/ _____/ _______

PATIENT INFORMATION

First ______________ MI ___ Last ___________________

☐ Male ☐ Female Date of Birth __/ __/ _______

Social Security # ________________________________

Marital Status: ☐ Single ☐ Married ☐ Other __________

___________________ _____________ _____ _________
Mailing Address City ST Zip

Phone Home: ( ) ____________ Cell: ( ) ___________

Best time to call? __________

Is it ok to leave a phone message? ☐ Yes ☐ No

Emergency Contact: ____________________________

Relationship: _____________ Phone ( ) ____________

Email (optional) ________________________________

Employed: ☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Student

Occupation _____________________________________

Employer ______________________________

Problem being seen for today? ___________________

Referred by: __________________________________

Primary care physician:__________________________

INSURANCE

Insurance Co. Name ____________________________

Act. # ____________________ Group # ___________

Policy holder, if other than self:

_______________________ Relationship ________

Secondary Ins ___________________________________

Act. # ____________________ Group # ___________

ASSIGNMENT & RELEASE

I understand that I am fully responsible for all charges incurred _________ **(please initial)**. I certify that I, or my dependent(s), have insurance coverage with the above noted insurance company(s) and authorize direct payment of benefits to Element Physical Therapy. If any payment(s) are mistakenly or purposely sent directly to me, or if payment is declined by my insurance company, I understand that I am financially responsible for the charges. I authorize the use of my signature on all insurance submissions. The above-named provider may use and disclose my healthcare information to the above named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian, or Personal Representative

____
Print Name of party noted above

___________________________ __/ __/ ________
Relationship to Patient **Date of Authorization**

IF BEING SEEN DUE TO AN ACCIDENT

Date of accident __/ __/ _______

Have you been seen for this condition by another provider? If so, who? ___________________________

Type of accident: ☐ Auto ☐ Work ☐ Home ☐ Other

Attorney (if applicable) ____________________________

With whom have you filed an accident report?

☐ Auto Ins ☐ Employer ☐ Worker Comp ☐ Homeowners

Name of Insurance Company

____

Claim # _____________________________________

Case Manager _______________________________

CM Phone # _________________________________

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