Sport Summit Physical Therapy

New Patient Information

Date: _____

Last Name: _____ First:_____ MI: _____
Preferred name/nickname: _____

If a minor, name of parent or legal guardian: _____

Date of Birth: _____ Age: _____ Sex: M_____ F:_____

Address: _____ Apt #: _____

City:_____ State: _____ Zip Code: _____

Cell phone: _____ Home phone: _____

Employer: _____ Work phone: _____

Emergency Contact: _____ Relationship: _____
Cell phone: _____ Home phone: _____

Insurance Company (if applicable): _____
Contract Number: _____Group Number: _____

Auto Insurance Company (if applicable): _____
Claim Number: _____Date of Injury: _____
Agent Name: _____Agent Phone: _____

NOTICE OF PRIVACY PRACTICES

I have been provided an opportunity to review the notice of privacy practices.

AUTHORIZATIONS

- I hereby authorize my insurance benefits to be paid directly to Sport Summit Physical Therapy. I am ultimately financially responsible for any and all non-covered services including but not limited to any deductibles, copayments, and/or any other professional services rendered that are not payable by my insurance company.
- I authorize Sport Summit Physical Therapy to release any information pertinent to my case to any insurance company, adjuster, or other medical person/entity.
- I hereby give Sport Summit Physical Therapy permission to provide treatment as prescribed by my physician.
- I certify that the information provided is true and current to the best of my knowledge. I will notify you of any changes in my health or the above provided information.
- I acknowledge and agree to provide payment(s) at the time of service.

Signature of Patient or Guardian: _____Date: _____