



Patient Information

Patient _____ Date _____
Last Name First Name Middle Initial
SSN _____ DOB _____ Gender Male / Female
Email _____
Billing Address _____ City _____ State _____ Zip _____
Home Address _____ City _____ State _____ Zip _____
Home # _____ Cell# _____ Employer _____
Occupation _____ Referring Dr. _____ Family Dr. _____
How did you hear about our clinic? _____

Emergency Contact

Emergency Contact: _____ Phone _____

Complete if patient is a minor

Father/Guardian _____ DOB _____
Home # _____ Work # _____
Mother/Guardian _____ DOB _____
Home # _____ Work # _____

RELEASE OF BENEFITS AND INFORMATION AND CONSENT TO TREATMENT: I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to *Rock and Armor Physical Therapy and Sports Performance* all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the clinic to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

I consent to treatment by the authorized personnel of *Rock and Armor Physical Therapy and Sports Performance* as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment, except in acts of negligence.

I have read and understand the Consent to Bill. _____ (initial)
I have read and understand the HIPAA Consent. _____ (initial)
I have read and understand the Attendance Policy _____ (initial)

Signed: _____ Date _____

(Parent or Guardian if patient is a minor.)