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.)