WELCOME TO ADVANCE PHYSICAL THERAPY

Please take a few moments to complete this form in its entirety. All information will be considered confidential, and will be released only as allowed through HIPAA regulations, and as considered necessary for treatment, payment, or other health care operations.

EMAIL ADDRESS_____

LAST Name _____ **FIRST Name**_____**MI**_____

Address_____

City_____**State**_____**ZIP**_____

Home Phone_____ **Work #**_____**Cell #**_____

Date of Birth_____ **SSN**_____**Sex** ❑ **M** ❑ **F**

Race ❑ **Asian** ❑ **Black** ❑ **Caucasian** ❑ **Other** ❑**Pacific Islander** ❑ **Decline**

Language ❑ **English** ❑ **Spanish** ❑ **Other** **Ethnicity** ❑ **Hispanic** ❑ **Non-Hispanic** ❑ **Decline**

Emergency Contact_____**Relationship**_____**Phone** _____

Area of Injury/Pain_____

Marital Status (check one) ❑ **Minor** ❑ **Single** ❑ **Married** ❑ **Divorced** ❑ **Widowed** ❑ **Separated**

Employer_____ **Occupation**_____

Address_____**City**_____**State**_____**Zip**_____**Work Phone**_____

How did you hear about our office? ❑ **Physician** ❑ **Former Patient** ❑ **Phone Book** ❑ **Other**

Referring Physician_____**Primary Care Physician**_____

Accident Related? ❑ **Yes** ❑ **No** **Type** ❑ **Auto** ❑ **Work** ❑ **Other** ***Date of Injury***_____

Work Comp Case Worker_____**Phone** _____

Lawyer (if applicable)_____**Phone**_____

RESPONSIBLE PARTY/GUARANTOR INFORMATION *(Complete this section only if information is different from patient)*

Name of person responsible for this account_____

Relationship to patient_____ **Daytime Phone**_____**Home Phone**_____

Address_____**City**_____**State**_____**Zip**_____

Employer_____**Employer Phone**_____

INSURANCE INFORMATION

Primary Insurance Carrier_____	**Secondary Insurance Carrier** _____
Insured Name_____	**Insured Name**_____
Relationship to patient_____	**Relationship to patient**_____
Policy/ID#_____	**Policy/ID#**_____
Group #_____	**Group #**_____
Insured Date of Birth _____	**Insured Date of Birth** _____
Insured SSN_____	**Insured SSN**_____
Insured's Employer_____	**Insured's Employer**_____

CONSENT TO TREAT/ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION

I consent to evaluation and treatment by authorized personnel of APT as may be dictated by prudent medical practice for my (or my dependent's) illness, injury, or condition. I authorize APT to bill the insurance carrier(s) or other third party payor named above and authorize assignment of benefits directly to APT. I also authorize release of medical information for the purposes of treatment, payment, or other health care operation for my case. (Refer to APT Billing Policy Statement).

PATIENT/RESPONSIBLE PARTY SIGNATURE _____**DATE**_____

Office Use Only

PATIENT_____**ACCT#**_____**SOC DATE** _____