River City Physical Therapy – Patient Information

Name _____ Today's Date_____/_____/_____
Last First MI

Mailing Address _____ _____ _____ _____
City State Zip

Sex: □ Male □ Female **Date of Birth**_____/_____/_____ email:_____

Phone (home) _____ **(cell)** _____
(Area code) Phone (Area code) Phone

Employer: _____ Phone_____

Who should we contact in the event of an emergency?

Name _____ Relationship _____ Phone _____

Primary care physician _____ Phone _____

The following relates to your payment for health care services provided. Please complete the following section carefully, and let us know if you have any questions.

- □ Please bill my insurance. I will provide you my insurance card to copy.
  We suggest that you call your insurance company so that you are fully aware of the criteria for physical therapy coverage on your plan.
- □ Please bill me directly at the above address or an alternative address that I have provided.
- Did this injury occur on the job? □ yes □ no If yes, date of injury: _____/_____/_____

Claim number: _____ Claims manager or contact person: _____

- Was this injury caused by a motor vehicle accident? □yes □no If yes, date of injury: ____/____/____

Claim number: _____ Claims manager or contact person: _____

I understand that if I have requested River City Physical Therapy to bill my insurance company as a service to me, I am responsible for meeting the criteria for payment dictated by my particular plan. I am aware that my plan may have a limited number of visits or a cap on the amount that may be reimbursed for services.
I hereby assign my insurance benefits to be paid directly to River City Physical Therapy. I also authorize River City Physical Therapy to release any information required to process this claim. I understand that I am fully financially responsible for non-covered services.

_____ _____
(signature) (date)

Release of Evaluation and Treatment for above patient if under age 18

As a parent or legal guardian, I, _____, consent to the physical therapy evaluation and treatment for this individual.

_____ _____ _____
(signature) (date) (relationship to patient)