APTC
ADVANCED PHYSICAL THERAPY CENTER

PATIENT INFORMATION

Patient Name: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Home Telephone #:** _____

E-Mail Address: _____ **Date of Birth:** _____

Social Security Number: _____-_____-_____ **MARITAL STATUS: M S D W**
(Circle one)

Spouse's Name: _____

Patient's Employer: _____ **Address:** _____

City: _____ **State:** _____ **Zip Code:** _____ **Work Telephone #:** _____

Name of (Primary) Physician: _____ **Telephone #:** _____

In case of emergency, who do we contact? _____
Telephone # : _____ **Cell Phone #:** _____ **Relationship:** _____

Whom may we thank for referring you to us? _____

I, _____ (please print clearly—if minor, parent or guardian signature) consent to evaluation and treatment by Advanced Physical Therapy Center, P.C., of my problem as diagnosed by my physician.

Please complete the following only if subscriber is not the patient or a minor:
Subscriber Name: _____ Date of Birth: _____
Employer: _____ Employer Telephone: _____
Employer Address: _____ City: _____ State: ___ Zip Code: _____

Are services related to a work or auto injury: (circle one if applicable) **WORK** **AUTO**
Date of Injury: _____ Claim Number: _____
Insurance Carrier: _____ Telephone: _____
Address: _____ Claim Representative: _____
City: _____ State: _____ Zip: _____ Representative Phone Extension Number : _____

ASSIGNMENT OF BENEFITS:
I hereby assign all medical benefits, to include major medical health benefits to which I am entitled, including Medicare, private insurance and any other health plan to Advanced Physical Therapy Center, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. If I receive direct payment from my insurance company for my physical therapy treatment, I will be responsible to bring this payment to Advanced Physical Therapy Center, P.C. to be applied to my account for services rendered. I certify this information is true and correct to the best of my knowledge.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
Advanced Physical Therapy Center, P.C. is authorized to provide and request from my referring physician, other physicians and/or my attorney, information regarding my diagnosis and medical condition for physical therapy while under their treatment. Information to be disclosed may include nature of the physical impairment, history, contributing factors, subjective symptoms, diagnosis, prognosis and other information pertinent to my treatment. Photostatic copy of this authorization shall serve in its stead.

Date: _____ Signature: _____