Physical Therapy Professional Center

**Patient Information**

Last Name: _____First Name: _____Middle Initial:_____

Address:_____

City:_____State: _____ Zip:_____

Date of Birth:_____Sex:_____ Social Security #_____

Home Phone #:_____Work Phone #:_____Cell #:_____

Marital Status: Single_____Married_____Divorced_____Widowed_____

Emergency Contact: _____Phone #_____Relationship_____

Occupation: _____

Primary Care Physician / Family Doctor(s) _____

Email: _____

How did you hear about PTPC, Inc? _____

**Insurance Information**

Insurance Name:_____

Insurance Policy #_____Group/Plan #_____

Policyholder's Name: _____Relation to Patient:_____DOB:_____

Insurance Address:_____

Medicare #_____ Part B effective date_____

***If Patient is a minor***

Responsible party for bill if other than patient:_____Relationship:_____

Responsible party's address (if other than above):_____

Date of Birth:_____ Social Security #_____

**Consent for Treatment:**

I hereby consent to receive care for therapy services by PTPC, Inc. I consent to medical treatment as is deemed necessary or advisable by the physical therapist.

**Consent to Release Medical Information:**

I authorize PTPC, Inc. to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

**Consent to Obtain Medical Information:**

I authorize PTPC, Inc. to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

**Assignment of Insurance Benefits:**

I hereby authorize payment to be made directly to PTPC, Inc.

**Guarantee of Payment:**

I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

**I hereby certify that I understand these rights as set forth.**

Patient/Responsible Party Signature_____Date:_____