

**Ascent Physical Therapy**  
**Lori Schwanz PT, DPT, MS, ATC, LAT, PC**  
**Cherie Havard PT, MSPT, LLC**  
**2712 Bee Caves Rd, Ste110, Austin, TX 78746**  
**Ph: (512) 732-2220 Fax: (512) 732-2227**

**Patient Information Record**

Patient Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street Apt. City State Zip

Phone \_\_\_\_\_  
Home Work Cell

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M ( ) F ( ) Marital Status: Married ( ) Single ( ) Other ( )

Social Security# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Drivers License# \_\_\_\_\_ State \_\_\_\_\_

Employer Name or School \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Referring Physician \_\_\_\_\_ Condition \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**Insurance Policy Holder**

Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to Patient \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ID#: \_\_\_\_\_ Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_

**Workers Compensation Information**

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ Claim#: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Ph: (\_\_\_\_) \_\_\_\_\_

Billing address: \_\_\_\_\_

**Local Person to Notify in case of Emergency**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**CONSENT TO CARE AND TREATMENT:** I, the undersigned, do hereby agree and give my consent to the physical therapists of Ascent Physical Therapy and their designees to furnish medial care and treatment to myself or my child considered necessary and proper by my physician and according to today's standards.

**MEDICAL INFORMATION:** I authorize the physical therapists of this office to release any information they have acquired in the course of my treatment, or my child's treatment, to my insurance company or companies or any third party payer so that they may obtain payment for medical / physical therapy services rendered.

**INSURANCE AUTHORIZATION:** I hereby authorize the physical therapists or staff of this office to furnish information to my insurance carriers concerning myself or my child's treatments.

**ASSIGNMENT OF BENEFITS:** I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim.

**I agree that I am financially responsible for the account even though Insurance may be pending on all or a portion of the charges.**

Signature of Patient or Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_