Ascent Physical Therapy, PC

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Patient Information Record

Patient Name_____
Last First Middle

Address_____
Street Apt. City State Zip

Phone_____
Mobile Home Office Ext.

Preferred phone number for communication: Mobile ☐ Home ☐ Office ☐

Date of Birth _____/_____/_____ Sex: M ( ) F ( ) Marital Status: Married ( ) Single ( )

Drivers License#_____ State_____

Email _____

Employer Name or School _____Occupation_____

Address_____
Street City State Zip

Referring Physician_____

Spouse/Parent Name_____ Work Phone_____ Home Phone_____

Insurance Policy Holder

Name of Insured_____ Date of Birth____/____/_____Relationship to Patient_____

ID#:_____Insurance Carrier_____ Phone_____

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 medical 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_____