Name: First		Middle	Last
Gender: Female Male		Date of Birth	Age
SSN :			Status : Single Married Divorced Other
Cell Phone: ( )			Home Phone ( )
Address :			
City:	State	Zip	
Employer :			
Referring Doctor :			Date of Next appointment
Reason for Visit today :			
Do you have a pacemaker?	**Yes**	**No**	
Was this an accident?	**Yes**	**No**	☐Auto ☐Work ☐Other (explain below)
Date of Injury			Date of Surgery
Currently on Home Health	Yes	No	
Physical Therapy this year	Yes*	No	
*Where /When			
Do you currently smoke	Yes	No	
SPOUSE/PARENT INFORMATION			
Last Name		First	
Telephone ( )		Relationship to Patient	
Emergency Information: Person other that spouse (Not living with you) to notify in case of emergency. (Local friend or relative)			
Name:			
Telephone ( )		Relationship to Patient	
Primary Insurance			
Subscriber's Name			DOB
Relationship to subscriber			Social Security #
Secondary Insurance			
Subscriber's Name			DOB
Relationship to subscriber			Social Security #

If I cannot be reached, a representative of PTA can give information about my healthcare or my bills to:

Name_____

Telephone_____ Relationship_____

Please indicate below with your initials if you agree:

_____ PTA may leave a message on my voicemail concerning my appointments, billing, and or medical information.

_____ PTA may send a text message concerning my appointments.

_____ PTA may send an email message concerning my appointments/ statements to

_____@ _____

PTA may release my health information to other doctors and staff who treat me. This could include healthcare providers who treat me who are not part of PTA.

PTA may release my health information to insurance companies or other companies that PTA uses to bill for services.

PTA may release my health information to companies that help PTA improve the quality and cost of care provided to patients by reviewing the health care provided by the practice.

Responsibility for Payment, Assignment of Benefits, Authorization and Medical Release

The above information is true to the best of my knowledge. I authorize Physical Therapy of Andalusia (PTA) to provide physical therapy treatment, test and procedures considered advisable by my physician. I guarantee payment in full of any and all claims and **charges in consideration for medical services rendered to me by PTA.** I authorize and demand the assignment of payment of my basic medical, major medical, third party medical, or any other medical benefits that may apply herein specified and otherwise payable to me, directly to Physical Therapy of Andalusia, Inc. I authorize PTA to release my medical information required to process my claims to my insurance company.

If for any reason the account should become delinquent, 30 days past last treatment day, I agree to pay all rebilling charges, interest of 10%, cost related to collection efforts, (a $25 processing fee) and reasonable legal fees. I have read and understand the policies as mentioned above.

I have read and understand the Physical Therapy of Andalusia payment policies.

X_____ X_____

Signature of Patient or Guardian Date