

MIND-BODY PHYSICAL THERAPY & WELLNESS CENTER PATIENT INFORMATION FORM

OFFICE USE ONLY
DX: _____

PLEASE PRINT LEGIBLY

TODAY'S DATE: _____

NAME: _____ SS#: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE #: _____ OTHER: _____
DATE OF BIRTH: _____ SEX: M / F (PLEASE CIRCLE ONE) MARITAL STATUS: _____
EMERGENCY CONTACT: _____
OCCUPATION / POSITION /DEPARTMENT: _____
ARE YOU? (CIRCLE ONE) FULL TIME PART TIME TEMPORARY RETIRED UNEMPLOYED
WORK PHONE # _____ EXT _____
EMPLOYER NAME AND ADDRESS: _____

ARE YOU A STUDENT? _____ IF SO, WHAT IS YOUR STATUS? (CIRCLE) FT or PT
REASON FOR YOUR VISIT TODAY? _____
WHEN DID SYMPTONS START? _____ HAVE YOU HAD THIS IN THE PAST? YES NO
IF YES, EXPLAIN: _____
IS THE REASON FOR BEING SEEN TODAY: AUTO RELATED or WORK RELATED or OTHER (CIRCLE)
IF YES, EXPLAIN: _____

INSURANCE INFORMATION

INSURANCE COMPANY NAME: _____
ID #: _____ GROUP #: _____ IS POLICY? (CIRCLE ONE) HMO PPO POS
RELATIONSHIP TO INSURED? (CIRCLE ONE) SELF SPOUSE CHILD OTHER

SPOUSE'S INFORMATION (IF PRIMARY CARDHOLDER)

SPOUSE'S NAME: _____ SS#: _____
DATE OF BIRTH: _____ SPOUSE'S EMPLOYER: _____

PRIMARY CARE PHYSICIAN

NAME: _____
ADDRESS: _____
PHONE & FAX #: _____
LAST DATE SEEN: _____

REFERRING PHYSICIAN

NAME: _____
ADDRESS: _____
PHONE & FAX #: _____
LAST DATE SEEN: _____

I, _____ hereby authorize **Mind – Body Physical Therapy & Wellness Center, Inc.** to apply for benefits from, _____ my insurance carrier, for payments to be made directly to **Mind – Body Physical Therapy & Wellness Center, Inc.**

I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all deductibles, co-insurance and co-payments required by my insurance company to be paid to **Mind – Body Physical & Wellness Center, Inc.** _____ (initial)

I will immediately inform **Mind – Body & Wellness Center, Inc.** of any changes to my insurance status. _____ (initial)

(IF APPLICABLE) I understand that I am out of network with my insurance and agree to cover all physical therapy costs not covered by my insurance. _____ (initial)

I hereby authorize **Mind – Body Therapy & Wellness Center, Inc.** to release all information necessary to secure payment of benefits. I authorize the use of my signature on all insurance submissions. I hereby give permission to _____ (doctor office) to release my medical records to **Mind – Body Physical Therapy & wellness Center, Inc.** _____ (initial)

I understand that I am required to give 24 hours notice for cancellations. Cancellations inside the 24 hour period will result in a \$20.00 charge. This charge is not covered by insurance. _____ (initial)

Signature _____ Date: _____