



PHYSICAL THERAPY: NEW CLIENT FORM

Today's Date: _____

First Name _____

Last Name _____

Address _____

City, State Zip _____

Email _____

Phone _____

Date of Birth _____ Gender _____

Social Security Number: _____

Emergency Contact (Name): _____

Emergency Contact Relationship: _____

Emergency Contact Phone Number: _____

Profession: _____

(student, employed, part-time employed, retired, other, self-employed, other)

Employer name: _____

Employer Address: _____



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Reasons for being seen by MindBodyPT:

- Auto Related
- Work Related
- Other

Start of symptoms: Please try to provide a date or occurrence, such as lifting a box or a fall.

Have these symptoms occurred in the past?

- Yes
- No

Have you received physical therapy in the past?

- Yes
- No

How many sessions of PT have you received?



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Insurance Information and Referring Physician Information

Insurance Name

Insurance ID Number

Insurance Group Number

Referring Physician

Name

Address

City, State Zip

Email

Phone

With my signature, I authorize the following:

For MindBody Physical Therapy & Wellness Center, Inc. to apply for benefits from my insurance carrier (listed above), and for payments to be made directly to MindBody Physical Therapy & Wellness Center, Inc. I will immediately inform MindBody Physical Therapy 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 MindBody Physical Therapy MindBody Therapy & Wellness Center, Inc. may release all information necessary to secure payment of benefits. I will allow my signature to be on file for all claims submissions. I hereby give permission to my physician listed above to release my medical records to MindBody Physical Therapy & Wellness Center, Inc.

Electronic Signature: _____

Date: _____



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