CREATIVE PATHWAYS PHYSICAL THERAPY

ADMISSION FORM

PATIENT INFORMATION

Patient Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Ph#:_____Work Ph#: _____
Email Address: _____
Employer Name: _____
Employer address: _____
City: _____ State: _____ Zip:_____

Date Injured: _____
SS#: _____
Marital Status: S M D W O
Date of Birth: _____ Sex: M F

Workers Comp: □Yes □No
Auto Accident: □Yes □No

PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL **_____SELF**

Insured (Responsible) Party Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Ph#:_____Work Ph#: _____

Relationship to Patient: _____
Date of Birth: _____
SS#: _____

PHYSICIAN INFORMATION

Referring physician: _____ Phone _____
Next visit to physician: _____

Primary Care: _____

INSURANCE INFORMATION

If you are being seen for an injury related to workers' compensation or an automobile accident, please give us the name of your workers' compensation/ automobile carrier instead of your primary personal medical insurance carrier.

Primary Insurance: _____ Phone: _____
Group #: _____Subscriber/ SS#: _____
Pt. relation to insured: Self Spouse Child Other
Do you have Secondary Insurance? □ Yes □ No Name: _____
Adjuster: _____Claim #: _____
Is your case in litigation? □ Yes □ No Attorney's Name: _____

How did you hear about Creative Pathways Physical Therapy? Friend/Relative/Physician/Insurance/ Website
Other: _____

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to Creative Pathways Physical Therapy **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not *covered* by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records. I *have* read, understand and signed the Creative Pathways Physical Therapy, PLLC. Financial Policy

Signed: _____ **Dated:** _____
Insured and/or Responsible Party

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Creative Pathways Physical Therapy, PLLC. I also understand that Creative Pathways Physical Therapy, PLLC. may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed: _____ **Dated:** _____
Insured and/or Responsible Party