SELF-PAY MEDICARE SUPERBILL
FIRST APPOINTMENT:_____
BODY PART:_____

OFFICE USE ONLY

PATHWAYS PHYSICAL THERAPY

PATIENT INFORMATION

FIRST NAME:_____

LAST NAME:_____

BIRTHDATE:_____ MALE/FEMALE/OTHER

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

PHONE NUMBERS:
CELL:_____HOME:_____WORK:_____

EMAIL:_____

REFERRED BY:_____

EMERGENCY CONTACT NAME:_____

PHONE:_____RELATIONSHIP:_____

I CERTIFY
THAT THE INFORMATION ABOVE IS CORRECT,
AND I UNDERSTAND PAYMENT IS AT THE TIME OF SERVICE.

SIGNATURE:_____

DATE:_____

IF YOU USE A SUPERBILL, PLEASE CALL YOUR INSURANCE COMPANY TO VERIFY OUT-OF-NETWORK PT BENEFITS.