Pathways Physical Therapy *Patient Information*
Puyallup and Federal Way

Patient Information Section

Name: _____ Home Phone: _____
Last/First/Middle Cell Phone: _____
Email: _____ Alternate Phone: _____

Address/_____ City/_____ State ____ Zip _____
Female ☐ Male ☐ Age/_____ Birth date/_____
Client Employer/School/_____ Occupation/_____
Employer address/_____ Work telephone/_____
Street/City/State/Zip
In case of emergency, who should be notify? Name/_____
Relationship/_____ Phone/_____

Primary Insurance Section

Primary Insurance Holder Name: _____
Last/First/Middle
Relationship to Patient/_____ Insurance Holders Birth Date/_____
Address (if different than patient)/_____
Street/City/State/Zip
Employer/_____ Occupation/_____
Business Address/_____ Business telephone/_____
Street/City/State/Zip
Insurance Company/_____ Cell telephone/_____
Insurance Contact and/or Adjustor's Name/_____ Telephone/_____
Group Number/_____ Subscriber ID Number/_____
If accident or incident, date it occurred/_____
Names of other dependents covered under this plan/_____

Additional Insurance Section

Is patient covered by additional insurance? ☐ Yes ☐ No (If yes, complete remainder of this section)
Subscriber's Name/_____ Relationship to Patient/_____
Subscriber's Birth Date/_____ Telephone/_____
Subscriber's Address (if different)/_____
Street/City/State/Zip
Subscriber's Employer/_____ Employer's Phone/_____
Insurance Company/_____ Contact Phone/_____
Group Number/_____ Subscriber ID Number/_____
Names of other dependents covered under this plan/_____

Assignment and Release Section

I certify that I and/or my dependent(s), have insurance coverage with _____ and assign directly to Pathways Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named service provider may use my health care information and may disclose such information to the above named insurance company (s) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Printed name of Patient, Parent, Guardian or Personal Representative

Notice of Privacy Practices Patient Acknowledgement

I have received *Pathways Physical Therapy* Notice of Privacy Practices written in plain language.
Name/_____ Date/_____
Signature of Patient/_____ Date of Birth/_____
Relationship to Patient (if signed by a personal representative of Patient)/_____
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