PATHWAYS PHYSICAL THERAPY

Patient Information/Update

Date: ________________

Patient Name: Last____________________________________ First ______________________________ MI_________

Address: ____ City/State_________________________ Zip____________

Home Phone: _____________________________________ Work Phone: _____________________________________

Email: ____ Cell Phone: ___________________________________

Sex: M / F Age: ___________ Birth date: ____

Primary Insurance Carrier: ____

ID#/Claim#: __________________________________ Group#: ____

Secondary Insurance Carrier (if applicable):____

ID#:____ Group#:____

Emergency Contact Name:________________________________ Phone:__________________________

Relationship to patient:_________________________

ASSIGNMENT AND RELEASE

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 clinic may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient/Guardian:____

Print Name of Patient/Guardian:____

Date: ______________________ Relationship to Patient: ___________________________