BELLINGHAM PHYSICAL THERAPY

PATIENT NAME____
First MI Last

Mailing Address ____________________________________ Home Phone ______________________

City ______________ State ____ Zip _______Work Phone ____________ Cell _____________________

Date of Birth ___-___-___ Sex: M__F__ Marital Status: S, M, D, W, LS **SSN** __________________________

Employer/School __________________________________ Status: Full time ___ Part time ___

Primary Care Physician _______________________ Referred By ______________________________

Emergency Contact ___________________________ Relationship ____________________________

Address ______________________________________ Home Phone __________________________

City __________________ State ____ Zip _________ Occupation ______________________________

Employer ____________________________________ Work Phone __________________________

Previous Surgeries ____

Do you have any metal implants? _________________________ Are you pregnant? Y___ N___

Do you have any allergies? (bees, lanolin, alcohol, latex, etc.) Y___ N___ Specify ______________________

Injured Area __________________________ Cause of Injury __________________________________

Date of Injury __________ Place of Injury: Work _________ Auto _________ Other _________

BILLING INFORMATION (please fill out all appropriate sections)

Medical Insurance

1. Primary Coverage _______________________________ ID/Claim #__________________________

Subscriber Name _____________________ **DOB** ___________ **SSN** ___________________________

2. Secondary Coverage to Medicare_____________________ ID/Claim #__________________________

Subscriber Name ___________________ **DOB** ___________ **SSN** _____________________________

L&I: Employer at Time of Injury ____________________________ Claim #_________________________

Claims Address ___________________________________ Phone # ____________________________

Motor Vehicle Accident: Personal Injury Protection___ Third Party Auto Insurance__________________

Date of Accident __________ Place of Accident ____

Name of Insured ___________________________ Relationship _______________________________

Auto Insurance ____________________________ Policy/Claim # _____________________________

Claims Address _______________________ City ___________ State____ Zip ______________________

Claims Adjuster ___________________________________ Phone # ____________________________

Attorney: Name ______________________________ Contact Person __________________________

Address _______________________________________ Phone # ____________________________

Scheduling Policy: We reserve the right to charge $35.00 and/or discontinue treatment for canceling/no-showing scheduled appointments when a 24-hour notice is not kindly given.

Payment Policy: I agree to pay any balance due when my maximum insurance benefits have been met, interest charges have been incurred (not to exceed 50% of the unpaid balance), any attorney fees, cost of suit, and/or any additional fees.

Assignment of Benefits: I authorize the release of any medical or other information necessary to process my claim. I authorize payment of medical benefits to Bellingham Physical Therapy, LLC for physical therapy services rendered. Also, if applicable, I request payment of government benefits to the party who accepts assignment, which is Bellingham Physical Therapy, LLC.

I consent to physical therapy treatment and the above conditions.

Signature: ____ Date: ______________