Alliance Physical Therapy
Because Experience Matters

Welcome to Alliance Physical Therapy. Please complete this packet and return it to the front desk along with your insurance card and photo identification. Thank you!

Patient Name:_____ DOB:_____ SSN:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone Number:_____ Email Address:_____

Health Insurance Information:

Medicare patients: Do you currently receive home health care?_____ Recent Discharge Date:_____

- Primary Insurance Name:_____ ID #:_____
  - Subscriber Name:_____ DOB:_____
- Secondary Insurance Name:_____ ID #:_____
  - Subscriber Name:_____ DOB:_____
- Additional Health Insurance Name: :_____ ID #:_____
  - Subscriber Name:_____ DOB:_____

Guarantor Name:_____ DOB:_____ Relationship_____

Address:_____ City:_____ State:____ Zip:_____

Workers Compensation Information:

Workers Comp Insurance Company:_____ Date of Injury:_____

Claim Number:_____ Adjuster Name/Number:_____

Place of Employment:_____

If legal action pending, please list attorney name/number:_____

Motor Vehicle Accident/Other Liability Accident:

Accident Date:_____ Accident State:_____ Found at fault? Yes – No – Unsure

Personal Policy: _____ Contact Name/Number:_____

Claim number:_____ Med Pay Available? Yes – No – Unsure

Third Party Policy: _____ Contact Name/Number:_____

Claim Number:_____ Med Pay Available? Yes – No – Unsure

If legal Action Pending, Please List Attorney Name/Number:_____

Initial the following:

____I was offered a copy of the assignment of benefits and consent to treat (one available upon request) and agree to all terms.

____ I was offered a copy of the appointment reschedule or cancelation policy (one available upon request) and agree to all terms.

CIRCLE ONE

I would like to receive my appointment reminders by: Phone Call – Text Message – No Reminder

____ I was offered a copy of the HIPAA Privacy Authorization information for (one available upon request) and agree to all terms and hereby authorize the release of my complete medical and financial personal health information to the following people:

Name:_____ Relation:_____ Phone Number:_____

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Name:_____ Relation:_____ Phone Number:_____

_____ I authorize Alliance Physical Therapy to appeal claims denied by insurance on my behalf.

Reason for today's visit:

_____

Personal Health History

Medications (You may provide a list to copy)

_____ _____

_____ _____

Allergies

_____ _____

_____ _____

Surgeries (type & approx. year)

_____ _____

_____ _____

Who is your PCP?_____ Who referred you?_____

Do you have a Living Will or DNR form? Yes – No (if yes please provide a copy)

How did you hear about Alliance Physical Therapy?_____

I agree that all information provided is true and correct to the very best of my knowledge and understand that I am responsible for providing accurate information to receive the best care.

Sign:_____ Date:_____

For Office Use Only

I had copies of all authorization and consent forms available and the patient requested/refused a copy.

Signature:_____Date:_____