

Andersonville Physical Therapy

Patient Information

Personal

Name _____

Street Address _____ Apt #: _____

City _____ State _____ Zip Code _____

E-Mail Address _____

(For newsletters, appointment reminders, etc.)

Phone
(H) _____ (W) _____ (Cell) _____

Date of Birth _____ Employer or Company Name _____

How do you prefer to be reminded of your appointments? email home phone cell

How did you hear about our services? (Check all that apply)

- | | |
|---------------------------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Referred by Doctor's Office
Name: _____ | <input type="checkbox"/> Phone book |
| <input type="checkbox"/> Referred by Another patient
Name: _____ | <input type="checkbox"/> Internet |
| | <input type="checkbox"/> Walk by |
| | <input type="checkbox"/> Other _____ |

I hereby direct and authorize Andersonville Physical Therapy to release to my insurance carrier(s) or other payors any medical or other information as may be necessary to determine benefits and process payment. I hereby authorize release of medical information to the referring physician. I authorize payment of medical benefits from a third party payor directly to Andersonville Physical Therapy. I understand that Andersonville Physical Therapy will file claims with my insurance company, however, do not accept responsibility of settling claims with my insurance company. I have received a copy of the missed appointment policy. **I fully understand that if I fail to give 24 hours notice when canceling an appointment I may be charged \$35.**

Signature _____ Date _____

I have also received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Signature _____ Date _____