White Mountain Physical Therapy

Patient Information

Name: _____ Date: _____
Last, First Middle

Patient Date of Birth: _____ Married / Single / Widowed

Social Security (of Guardian if Patient is a Minor): _____ Male / Female

Name and Date of Birth of Guardian if Patient is a Minor: _____

Physical Address: _____
City, State Zip

Mailing Address: _____
City, State Zip

E-Mail Address:_____
Home Phone: _____ Cell Phone: _____
Emergency Contact: _____Phone Number: _____
Referring Doctor: _____Phone Number: _____
Primary Care Doctor_____Phone Number_____
Date of Surgery: _____Date of Injury: _____
Diagnosis: _____Freq/ Duration on Referral: _____
Are you currently enrolled in Home Health? Yes / No Have you had Physical Therapy this year? Yes/No

Workman's Comp: _____ **Case Worker:** _____
Phone Number: _____**Fax Number:** _____
Claim Number: _____Employer: _____
Claims Mailing Address: _____

Primary Insurance Co.: _____**Phone Number:** _____
ID Number: _____**Group Number:** _____
Insured's Name: _____ SSN: _____DOB: _____

Secondary Insurance Co: _____**Phone Number:** _____
ID Number: _____ **Group Number:** _____
Insured's Name: _____SSN:_____DOB: _____

Financial Policy: I hereby authorize my primary and secondary insurance company to make payments directly to White Mountain Physical Therapy. I understand that I am responsible for knowing the details of my insurance policy including the extent of benefits. I am personally responsible for all allowable charges not covered by my insurance and all charges remaining after my insurance has paid the portion for which it is responsible. I authorize White Mountain Physical Therapy to release any and all information required to process a claim for payment as allowed by law.

I have read and understand the Financial Policy and Appointment Policy for White Mountain Physical Therapy. I understand that these policies are subject to change at the discretion of the management and that I have a right to be notified of substantial changes. I agree to abide by these policies.

Patient/ Guardian Signature: _____
Printed Name: _____ **Date:** _____