Performing Arts Physical Therapy, PC

PATIENT INORMATION
Name_____ **Male**___ **Female**____
Address_____ **Date of Birth**_____
City, State, ZIP _____
Phone: Home_____ **Cell** _____ **e-mail**_____

RESPONSIBLE PARTY
(STUDENTS SHOULD PROVIDE A PARENT/GUARDIAN'S HOME ADDRESS)
Name_____
Address_____
City, State, ZIP_____
Phone_____
Relationship to patient_____

INSURANCE
Primary_____ **Phone #**_____
Address_____
City, State, ZIP _____
Subscriber_____ **Date of Birth**_____
Relation to Patient_____ **Employer**_____
ID#_____ **Group #**_____

Secondary _____ **Phone #**_____
Address_____
City, State, ZIP _____
Subscriber_____ **Relation to patient**_____
ID #_____ **Group #**_____

I hereby authorize treatment to be rendered by Performing Arts Physical Therapy, PC. If necessary, I authorize release of medical and billing records to the following: Insurance Carrier, Attorney, and or Employer (Worker's Comp cases only).

I acknowledge that I am responsible for charges incurred as a patient of Performing Arts Physical Therapy. I understand that a $80.00 fee will be charged for all cancellations with less than 24 hours notice.

Signed _____ **Date**_____
Parent/Guardian (if patient is under 18)_____