Hoquiam Physical Therapy Services

Patient Information ____

Last Name_______________________________First Name_______________________MI_______

Mailing Address____Zip________________

Home Phone ______________________Cell______________________Work____________________

Date of Birth _________________SSN ____________________Gender ______Marital Status________

Emergency Contact_____________________Relationship_____________Phone___________________

Referred By____________________________Primary Care Physician___________________________

Are you receiving any Home Health services? **Yes** **No**

Have you had any Physical Therapy this year? **Yes** **No**

Is this injury related to a Motor Vehicle Accident? **Yes** **No**

Is the reason for your visit due to a Work-Related Injury? **Yes** **No**

Worker's Compensation Insurance Company ____

Claim # _____________ Claim Manager __________________ Phone # ____________________

Primary Insurance Plan______________________ID______________________Group_____________

Subscriber_________________________Relationship_______________ Date of Birth________________

Secondary Insurance Plan____________________ID______________________Group_____________

Subscriber_________________________Relationship_______________ Date of Birth________________

I give my consent and authorization to Hoquiam Therapy Services to treat my condition. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I acknowledge I must notify Hoquiam Therapy Services immediately to any changes regarding my health insurance plan or coverage. I authorize the release of all information necessary to secure the payment of insurance benefits.

Signature of Patient/Guardian__________________________________ **Date**_____________________