

WELCH PHYSICAL THERAPY & SPORTS MEDICINE
Patient Information Sheet

NAME: First _____ MI _____ Last _____

Address _____

City _____ State _____ Zip Code _____ E-Mail _____

Home Phone _____ Work/Mobile Phone _____

Social Security # _____ Marital Status M / S / W / D (circle one)

Date of Birth _____ Sex M / F (circle one) Employer _____

Referring Physician _____ Referred By: Physician, Insurance Plan, Other (circle one)

Emergency Contact Name _____ Phone _____

Primary Insurance _____ Insured Employer _____

Name of Insured _____ Insured ID# _____

Insured Date of Birth _____ Insurance Company Telephone # _____

Secondary Insurance _____ Name of Insured _____

Insured ID# _____ Insured Date of Birth _____

What type of injury are you being seen for? _____ R L Both (Circle One)

Date of Injury/First Symptoms _____ Workmen's Comp. _____ Auto Accident? _____ Other? _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/FINANCIAL POLICY

I, the undersigned or designated representative for the patient, hereby assign all medical benefits to which I am entitled to *Welch Physical Therapy & Sports Medicine* in the event they file insurance on my behalf. I hereby authorize *Welch Physical Therapy & Sports Medicine* to release all information necessary to secure the payment of said benefits. I understand I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the standard rates and payments terms of this office. If it is deemed necessary, at the sole discretion of this office, to refer my account to a collection agency as a result of nonpayment, I patient/and/or guarantor agrees to pay all cost of collection including attorney fees, collection fee, and contingent fees to collection agencies of not less than 35% of the delinquent balance, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

CANCELATION POLICY: *Appointments not canceled prior to their scheduled time will be assessed a \$25.00 fee.*

Kindly sign and date this form to indicate that you understand and agree to these conditions.

Signature _____ Date _____