



Date: _____

Patient Information

Last Name:		First Name:		MI:
Address, City, St, Zip:				
Phone: Home:		Cell:	Work:	
Email:			Age:	Birthdate:
Sex: M F	Marital Status:	SSN:	Are you pregnant: Yes No NA	
Referring Physician:			MD Phone:	
Was this a job related or auto accident? Yes No			Date of Accident:	
Reason for today's visit:				
Occupation:			Employed: Yes No	

Emergency Contact Information

Name:	Phone:	Relationship:
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Insurance Information

Primary Insurance:	ID #:	Group #:
Insured Name:	Birthdate:	Sex: M F Relationship:
Insured Employer:		
Secondary Insurance:	ID#:	Group #:
Insured Name:	Birthdate:	Sex: M F Relationship:

If L&I Claim:

Claim #:	Date of injury:
Claim Manager:	Claim Mgr Phone:

If Motor Vehicle Accident:

Claim #:	Date of Accident:
Claim Manager:	Claim Mgr Phone:

Financial Agreement: I understand, as the patient and/or above-mentioned responsible party that I am fully responsible for payment of all charges incurred. I authorize my insurance benefits to be paid directly to **Restoration Physical Therapy, LLC** for services rendered. I understand I am financially responsible for any deductibles, co pays, co-insurance, non-covered services, or non-authorized services. I authorize Restoration Physical Therapy, LLC to release any information requested by the insurance company with regards to payment of benefits.

Signature: _____ Date: _____

I am aware of the cancellation/no show policy of Restoration Physical Therapy, LLC, which reserves the right to charge a patient who fails to keep a scheduled appointment or cancels with less than 24 hours notice. This fee of \$50 cannot be billed to the insurance company. _____ (Initials)