LifeStyle Physical Therapy **Patient Information Form**

Please PRINT AND complete ALL sections below!

Patient's Personal Information

(Circle one) Martial Status: Single Married Divorced Widowed Sex: Male Female

Name: Last First Middle Date of Birth:

Street Address: City: St: Zip:

Home Ph: Work Ph: SS# :

Employer/Name of School: Email Address:

Spouse's Name: Spouse's Work Ph:

Patient's Responsible Party Information

Responsible party: Date of Birth: SS# :

Relationship to patient: Home Ph: Work Ph:

Employer's Name: Phone # :

Address: City: St: Zip:

Spouse's Employer's Name: Spouse's Work Ph:

Patient's Insurance Information

PLEASE PRESENT INSURANCE CARD

PRIMARY Insurance Company's Name:

Insurance Address: City: St: Zip:

Name of Insured: Date of Birth Relationship to insured:

Insurance Id # : Group # :

SECONDARY Insurance Company's Name:

Name of Insured: Date of Birth Relationship to insured:

Insurance Id # : Group # :

Credit Card Information

Name as if appears on the card:

Card #:

Expiration Date: Type of Card:

SSID # (three digit number on the back of the card)

Assignment of Benefits and Release of Information- Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits be made directly to LifeStyle Physical Therapy, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance and my credit card will be charged. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and also authorize the release of any confidential patient information to assist in treatment. I further agree that a photocopy of this agreement shall be as valid as the origional.

Date: Signature: