BreakThrough PHYSICAL THERAPY

Newest Research, Fewest Visits, Best Results

Name:_____ Date of birth:____/____/_____
(last) (first) (M.I.)

SS number:_____ Marital Status: M D S Other Gender: M F

Address:_____ City:_____ State:_____ Zip:_____

Phone: (home) _____ (cell)_____ E-Mail address:_____

Ins Subscriber's full name:_____ Ins Subscriber's SS# & date of birth _____

Emergency contact:_____ Emergency contact number:_____

Referring MD:_____ Referring MD phone #:_____

Employer:_____ Phone (work):_____

Did a family member or friend recommend us to you? Y N If yes, who was the treating PT? _____

If no, how did you choose us for your physical therapy? Radio Print Ad MD Location Website

Yellow pages Insurance Other:_____

Is your injury/condition a result of a work related incident? Yes No

Medicare Only

Have you had any physcial/speech or occupational therapy so far this year? Yes No

If YES, where and when did you have it: _____

Do you have a home health care agency coming to your house? Yes No

If YES, who is the agency and what is the phone number: _____

Do you have secondary insurance? Yes No

Workers' Compensation Only

Ins Co:_____ Address:_____ City:_____ State/Zip_____

WCB#: _____ Claim #: _____ Phone #:_____

Date of Injury/accident:_____ Employer:_____ Employer contact:_____

Employer ph #:_____ Attorney:_____ Attorney ph #:_____

I, _____ hereby authorize and instruct my insurance carrier to pay BreakThrough Physical Therapy, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

_____ _____
Insured or Authorized Person's Signature Date