Patient Information

Patients Name: ______________________ Date of Birth: ______________________
Address: ______________________ City, State, Zip: ______________________
SS #: ______________________ Email: ______________________
Phone #'s: (Home) ______________________ (Cell) ______________________
Emergency Contact: ______________ Relation: __________ Phone: __________
Referring Physician: ______________________ Phone: ______________________
Preferred Method of Communication: ☐ Email ☐ Text Message ☐ Phone
I Agree to Receive Emails From Fit PT (for therapist and clinic communication only): ☐ Yes ☐ No
Who Can We Thank For Your Referral: ______________________
Have you had Home Health: ☐ Yes ☐ No If yes, how many visits: ________
Have you been Discharged from Home Health: ☐ Yes ☐ No

Insurance Information

(Please Provide Us with a Copy of Current Drivers License and Insurance Card)
Primary Payment Source: ☐ Insurance ☐Self ☐ Workers Comp ☐Auto/Personal Injury ☐Other
Primary Ins: ______________ Member ID #: ______________ Group #: ________
Secondary Ins: ______________ Member ID #: ______________ Group #: ________
Claim #: ______________ Adjuster/Attorney Name/ Phone #: ______________

(Complete only if responsible party is not patient and/or if patient is minor)
Guarantor Name: ______________ Relation to pt: ________ Date of Birth: ________

Authorization

Your signature below acknowledges you understand and agree the following:

Authorization for Information Release:
I authorize Fit Physical Therapy to furnish my insurance company with medical information they may request regarding your condition or treatment. I also authorize Fit Physical Therapy to communicate with my referring health care provider regarding any medical information needed for treatment. Furthermore, I authorize my referring healthcare provider to release any Diagnostic Reports, Imaging (X-Rays, MRI, CT scans) and surgery reports related to my care to Fit Physical Therapy.
Privacy Notice and Patient Bill of Rights:
I have read and understand Fit Physical Therapy's Privacy Notice and Patient Bill of Rights
Authorization for Treatment:
I authorize Fit Physical Therapy to provide physical therapy treatment to the above named patient.
I am at least 18 years of age and/or the legal guardian/guarantor of the above named patient.
Chaperone Policy
Every patient has the right to have a chaperone present in the room during office visit. If you wish to have a chaperone in the room, please let the office staff know, and once of your choosing or an office personnel will be provided to you.

Printed Name of Patient: ______________________

Signature of Patient and/or Legal Guardian: ______________________ Date: __________