Personal Information

Patient Name_________________________ , ______________________ ____ **Today's Date**____________
(Last) *(First)* *(MI)*

Date of Birth_________________________ **Gender** *M / F*

Address ____**City**______________**State**________**Zip** ________

Home Phone___________________**Work Phone**_________________________**Cell phone**_______________

Email ____**May we contact you by email?**________________

May we leave confidential information on voicemails for numbers listed above? _____________________

May we communicate with you by non-HIPAA compliant text, for your convenience?________________

Parent name (if patient is minor)_____________________________

Emergency Contact Information

In Case of an Emergency, who may we contact?_________________________**Relationship?**____________

Emergency Contact Phone ___________________**Work**___________________**Cell**____________________

May we discuss your care, schedule and billing information with the person listed above? _____________

Referring Physician Information

Name of Referring Physician _______________________________**Dr. Phone #**___________________________

Name of Primary Care Physician (if different from above) ____

Authorization to release information:

I hereby authorize Ascent Physical Therapy to release information to my physician, insurance company, and any other pertinent medical provider any information acquired in the course of my treatment. I authorize my other medical providers to release any medical information requested by Ascent Physical Therapy.

Signature of Patient (or Guardian) ____

Payment Policy:

I hereby authorize payment of all benefits directly to Ascent Physical Therapy for medical services rendered. Ascent Physical Therapy will not balance bill me for costs above the allowed amount. If Ascent Physical Therapy is not in-network with my insurance, I agree to pay _________ per visit for services and Ascent Physical Therapy will bill my insurance for out of network benefits, if available.

Signature of Patient (or Guardian)____