Welcome to
Crossroads Physical Therapy

Thank you, for selecting our office. In order to serve your properly, we will need the following information. All information will be strictly confidential. (please print)

PATIENT INFORMATION ***Today's Date***

Email Address* _____

Your email will NOT be shared. We will use it for occasional office announcements

Patient's First Name _____ Last Name _____

Age _____ Date of Birth _____/_____/_____ Sex **M or F**

Marital Status Single___ Married___ Divorced___ Widow___ Other ___

Patient's Occupation _____

Mailing Address City ST Zip

Best # to call Home# Cell# Work#

S/S# Driver's Lic

Emergency Contact Person _____ Phone # _____

Relation to patient

Physician Name _____ Phone # _____

Address _____

Nature of Injury ***Auto Accident ____*** ***Work Injury ____*** ***Other _____***

MEDICAL INSURANCE INFORMATION

Primary Insurance

Subscriber's Name: Subscriber's DOB

Employer

Id # Group #

Patient's Relationship to Subscriber / **self** / **spouse** / **parent** / **guardian** / **other**

Secondary Insurance

Subscriber's Name Subscriber's DOB

Employer

Id # Group #

Patient's Relationship to Subscriber / **self** / **spouse** / **parent** / **guardian** / **other**

Financial

Financially Responsible Party Name:

Address_____

City ST Zip

Name of Insured _____

I authorize this office to release any information necessary to process the insurance claims. I understand that I am fully responsible for all charges, regardless of insurance coverage. Verification of coverage is not a guarantee of payment. Crossroads Physical Therapy is not responsible for your insurance misquoting benefits. Crossroads Physical Therapy expects prompt payment of services rendered, not withstanding any insurance of other 3rd party arrangements. By signing this agreement and accepting treatment from Crossroads Physical Therapy, you agree that Crossroads Physical Therapy has the right to discontinue future treatments if you have invoices outstanding more than 120 days.

X **X**

Patient, Parent or Guardian Signature Date

Crossroads Physical Therapy Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Crossroads Physical Therapy Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Crossroads Physical Therapy and of my rights, with respect to my health information.
I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

X_____ **X**_____
Patient's Signature **Date**

X_____ **X**_____
Signature of Patient's Representative if patient is unable to sign **Date**