St. George Physical Therapy

New Patient Data

PATIENT (Last, First, MI):_____ AGE:_____

DATE OF BIRTH:_____ PATIENT STATUS: ____Single ____ Married ____Other

ADDRESS:_____CITY, STATE, ZIP:_____

HOME PHONE:_____ SOCIAL SECURITY NUMBER: _____

EMPLOYER:_____ JOB TITLE:_____

EMPLOYER ADDRESS:_____EMPLOYER PHONE:_____

EMERGENCY CONTACT:_____ RELATION:_____ EMER. PHONE_____

**If you would like to share an email address to receive insurance (particularly Medicare) updates, and/or information pertinent to your treatment, we will happy to add you to our email list.

Email Address:_____ (FOR APPT. REMINDERS)

FINANCIAL INFORMATION

{ } Medicare (Have card available) { } Self-Pay

{ } Insurance (Have card available) { } Workmens' Compensation

Insured is: { } Self { } Spouse { } Child { } Other

If Other than Self, complete: Insured Name_____ Insured D.O.B._____

Insured Employer_____ Insured SSN: _____

Insurance Plan Name:_____Insurance Phone #:_____

Insurance Claims Address:_____

Insured's I.D.# (if not SSN):_____Group #:_____

Benefits Given By: _____ Date:_____ Self-insured (?)_____

Deductible:_____Co-Insurance_____Co-Pay_____

Authorization Needed (?): Y N Authorization Number:_____

**I hereby ASSIGN PAYMENT OF MY MEDICAL BENEFITS directly to St. George Physical Therapy for treatment received.

**I understand that I am financially responsible for any charges incurred at St. George Physical Therapy as a result of treatment, that are not paid/covered by insurance/third-party payors.

**NO SHOW CHARGE: Our time is valuable, just as is your time, and there are other people who wish to receive treatment. Therefore, there is a $55.00 charge for each appointment not kept. There will be no charge for any appointment cancelled the day prior to your appointment, or if we are able to fill the appointment. Your consideration is appreciated.

PATIENT/GUARANTOR SIGNATURE:_____DATE:_____

WITNESS SIGNATURE_____

Ins. Verified ____Yes ____No

SGPT/VS/04-16-2001