# Patient Information

The Physical Therapy Place

2401 E 42nd Avenue, Suite 103, Anchorage AK 99508

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Patient Name | | | SSN | | | Date of Birth | | |
| Address | | | Date of Injury or Onset (mm/dd/yy) | | | How did you hear about us? | | |
| City | State | Zip | Medical Providers: | | | | | |
| Home Phone | Mobile Phone | | Male | Female | Single | Married | Occupation | |
| Work Phone | E-mail contact | | Please complete the *Spouse* or *Parent* information below**, if covered by their insurance**. | | | | | |
| Patient's Employer | | | Name of Spouse or Parent | | | | Relationship | |
| Address | | | SSN | | | | Date of Birth | |
| City | State | Zip | Employer | | | | Phone | |

☐ *Please bill my Primary* ☐ *Secondary* ☐ *Please bill Workman's Comp or Accident* ☐ *I will be paying the bill in full insurance*

*PLEASE PRESENT YOUR INSURANCE CARD(S) FOR COPYING*

| | | |
|---|---|---|
| Primary Insurance | | Secondary Insurance |

***MOTOR VEHICLE** OR **WORKERS COMPENSATION** Patients PLEASE COMPLETE THE FOLLOWING INFORMATION*

| | | | |
|---|---|---|---|
| CLAIM NUMBER: | | | Date of Injury/Accident: |
| Insurance Company Name | | | Adjustor's Name |
| Insurance Company Address | | | Adjustor's Phone |
| City | State | Zip | Insurance Company Phone |

*IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?*

| | | |
|---|---|---|
| Name | Relationship | Home Phone |
| Address | City, State, Zip | Cell Phone |

***The Physical Therapy Place Cancellation Policy:** There is an $80 charge for NO SHOW appointments. This is the patient responsibility and is not paid by insurance. If you are unable to make your appointment, please call within a 24 hour notice to cancel or reschedule.*

**Consent for Treatment**: I consent to treatment and authorize the staff of THE PHYSICAL THERAPY PLACE, LLC to render whatever services are necessary for the care of myself and/or my family member.

***SIGNATURE:*** ***DATE:***

**Medical Release:** I hereby authorize the release of medical information to my insurance carriers concerning my condition and treatments. I hereby assign The Physical Therapy Place, LLC payments for medical services rendered to myself and my dependents.

***SIGNATURE:*** ***DATE:***