



Patient Information

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 <i>Spouse or Parent</i> 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		
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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: