HaydenLake
PHYSICAL THERAPY & AQUATICS

Legal Name _____ Nickname _____ Male _____ Female _____
Home Phone _____ Cell Phone _____
Street Address / PO Box _____
City, State _____ Zip _____
Date of Birth _____ Social Security Number _____

Would you like appointment reminders? Please choose only one option:
Email _____ Text _____ Voice Call to Cell _____ Voice Call to Home _____
Email address for appointment reminders (please print clearly) _____
May we leave a detailed message at: Home _____ Cell Phone _____ Work _____ None _____
Employer Name and Address _____
Employer Phone_____ Spouse's Employer _____
Spouse's Name_____ Spouse's Phone _____
Parent's Name (if patient is a minor) _____
Who is financially responsible for your bill? _____
Nearest relative not living with you _____
Whom may we contact in case of emergency? _____ Phone _____
Physician _____
Have you had any prior Physical Therapy this calendar year? Yes _____ No _____
Are you having or have you had in-home therapy (P.T. or O.T) within the last month? Yes _____ (Last date _____) No _____

Insurance Information (If the patient is not the insurance subscriber, please complete the subscriber's name and date of birth.) Medicare _____ Medicaid _____ Private Ins. _____ Worker's Comp _____ MVA _____ Cash _____
Name of Insurance Company _____
Insurance Company Address _____
Phone_____ ID/Claim Number _____ Group Number _____
Subscriber_____ Social Security Number _____ Date of Birth _____
Date of Injury_____ Briefly Explain _____

Release of Information/Treatment Consent

I do hereby consent to Physical Therapy treatment for myself or my child (**Patient's Name**) _____.
I authorize you to furnish my doctor and/or insurance company with pertinent information regarding my treatment.

Insurance Authorization

I authorize the release of any information necessary to process this claim and hereby instruct and direct my insurance company to pay Hayden Lake Physical Therapy and Aquatics for medical services.

I understand and agree (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient Signature_____ Date_____
Parent's Signature (if patient is a minor)_____ Date_____
Parent's Social Security Number_____ Parent's Work Phone _____

Please read financial agreement and cancellation information on back.