AXCESS PHYSICAL THERAPY

Patient Information

Last Name	First Name	Middle	
Address	City	State	Zip
Social Security Number	Date of Birth / Age	Sex M F	Marital Status S M W D

Preferred communication method:

Phone Numbers:

Can we call your Cell?: Yes No

☐ Home:

Can we Text you?: Yes No

☐ Work:

Can we E-mail: Yes No

☐ Cell:

E-Mail:

Occupation	Employer	Employer Telephone	
Employer Address	City	State	Zip
Referring Physician	Referring Physician Phone		

How did your injury occur?

Emergency Contact (Note: Different from your home information)

Name	Relationship
Home Phone	Work or Cell Phone

Secundary Insurance

Insurance Holder Name / DOB	Relationship
Home Phone	Work or Cell Phone

Workers Compensation Information			
Work related injury ☐Yes ☐No	If yes, date of accident:	What state was the claim filed in?	
Name of Worker's Compensation Carrier		Claim Number	
Address		City	State	Zip
Phone number	Date last worked		
Adjuster's name	Phone number		
What body part was injured?	How did the injury occur?		

Accident related injury information			
Motor vehicle/Personal related injury ☐Yes ☐No	If yes, date of accident:		
Motor vehicle compensatioin Carrier	Claim number		
Address	City	State	Zip
Phone number	Agent name		

Attorney Information			
Attorney's Name (if lawsuit is involved)	Phone number		
Address	City	State	Zip

Consent of Disclosure

I hereby give consent to Axcess Physical Therapy, LLC to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient _____ Date _____

If you are signing as the patient's representative:

Print your name: _____

Relationship:

Financial Responsibility

I understand fully that in the event my insurance company/responsible party does not pay for the services I receive, I will be financially responsible, including any cost of collection, attorney fees and court costs that may occur. I will be responsible also for any deductable not met.

Signature of Patient _____ Date _____

Authorization of Payment and Release of Information

I authorize the release of any medical or other information necessary to process my medical claims. I also request payment of benefits to the supplier for services received from Axcess Physical Therapy.

Signature of Patient _____ Date _____