Welch
Physical Therapy
WelchPT.com

WELCH PHYSICAL THERAPY & SPORTS MEDICINE
Patient Information Sheet

NAME: First____________________________MI______Last_________________________________

Address____

City_____________________State__________Zip Code_______________E-Mail_________________

Home Phone_______________________Work/Mobile Phone_____________________________

Social Security #___________________________ Marital Status M / S / W / D (circle one)

Date of Birth _________________ Sex M / F (circle one) Employer___________________________

Referring Physician________________________Referred By: Physician, Insurance Plan, Other (circle one)

Emergency Contact Name_____________________________________Phone_____________________

Primary Insurance____________________________Insured Employer___________________________

Name of Insured________________________________ Insured ID#_____________________________

Insured Date of Birth__________________Insurance Company Telephone #______________________

Secondary Insurance__________________________Name of Insured____________________________

Insured ID#______________________________Insured Date of Birth__________________________

What type of injury are you being seen for?__________________________ R L Both (Circle One)

Date of Injury/First Symptoms___________Workmen's Comp.____ Auto Accident?____ Other?____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/FINANCIAL POLICY

I, the undersigned or designated representative for the patient, hereby assign all medical benefits to which I am entitled to *Welch Physical Therapy & Sports Medicine* in the event they file insurance on my behalf. I hereby authorize *Welch Physical Therapy & Sports Medicine* to release all information necessary to secure the payment of said benefits. I understand I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the standard rates and payments terms of this office. If it is deemed necessary, at the sole discretion of this office, to refer my account to a collection agency as a result of nonpayment, I patient/and/or guarantor agrees to pay all cost of collection including attorney fees, collection fee, and contingent fees to collection agencies of not less that 35% of the delinquent balance, such contingency fee to be added and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.
CANCELATION POLICY: ***Appointments not canceled prior to their scheduled time will be assessed a $25.00 fee.***

Kindly sign and date this form to indicate that you understand and agree to these conditions.

Signature____Date_____________________________