SOUTH BOISE PHYSICAL THERAPY

7421 W. Victory Rd. Ste. 103, Boise, ID 83709 * Phone 1-208-514-3736 * Fax 1-208-514-3672

Patient Name:_____ Male_____ Female_____ Date of Birth:_____

Address:_____ City:_____ State:_____ Zip:_____

Email:_____ Phone:_____ SSN:_____

Referring MD and Clinic Location:_____

Employer:_____ Employer Address and Phone:_____

Spouse or Partner Name (if they are the primary insured):_____ Date of Birth:_____

PLEASE COMPLETE IF INSURANCE IS A WORKER'S COMPENSATION CLAIM:

Date of Injury:_____ Insurance Company:_____ Claim #:_____

Examiner Name:_____ Examiner Phone Number:_____

PLEASE COMPLETE IF PATIENT IS A MINOR: I authorize the physical therapy providers at South Boise Physical Therapy to administer treatment as deemed necessary and adjust treatment plans as needed in my absence.

Parent/Guardian Name(s):_____ DOB(s):_____

Parent/Guardian Address(s):_____

Parent/Guardian Phone Number(s):_____

EMERGENCY CONTACT INFORMATION:

Authorization for Release of Information: I authorize release of the following information to the person(s) listed below:

All Medical/Billing:_____ Appointment Information Only:_____

Name(s):_____ Phone Number(s):_____

Relationship(s) to Patient:_____

I authorize South Boise Physical Therapy to use and disclose health and medical information for the purposes of treatment, payment, and health care operations. I authorize South Boise Physical Therapy and it's providers to email me to the address I have provided above with information regarding my scheduled appointments, billing statement, or physical therapy treatment information directly from a provider in the clinic. Under all circumstances I assume final responsibility for my account understanding that in the event that my account becomes delinquent, I agree to pay accrued finance charges , court costs, and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to South Boise Physical Therapy for services rendered. I have received this practice's Notice of Privacy Practices written in plain language and was offered a hard copy to take with me.

Patient Signature:_____ Date:_____

Printed Patient Name:_____