PATIENT INFORMATION

Last Name _____First _____MI_____ Date _____
Home Address _____ Home Phone _____
City, State, Zip _____Work Phone_____
E-Mail _____ Cell Phone _____
Birth Date _____ Age _____ Sex: M/F Status: S M D W
Employer _____Attorney (if applicable) _____
Emergency Contact _____ Phone _____
How did you hear about Pike Creek Physical Therapy? _____
_____

SPOUSE INFORMATION

Last Name _____First Name _____ MI _____
Employer _____ Work Phone _____Cell Phone _____
Birth Date_____

IF PATIENT IS A MINOR PLEASE COMPLETE

Parent/Guardian's Name _____Birth Date_____
Address (if different than above) _____
Home Phone _____
Place of Employment _____Work Phone _____

Authorization to Pay Insurance Benefits:
I hereby authorize payment directly for all benefits to me under the terms of my insurance policy with respect to service provided for myself or my dependents.

I understand that I am financially responsible for any balance of charges not covered by my insurance including deductibles and/or co-payments and any collection agency fees.

Authorization to Release Medical Information:
I authorize Pike Creek Physical Therapy and /or Southern Delaware Physical Therapy Inc. to release any medical information necessary to process this claim and/or coordinate my care.

Consent for Treatment
I give my consent to Pike Creek Physical Therapy and/or Southern Delaware Physical Therapy Inc., its staff and related associates to provide outpatient physical therapy services considered necessary and proper for my diagnosis. I accept that treatment does not guarantee improvement and may, at times, exacerbate symptoms.

Signature _____ DATE _____
(Signature needs to be of parent or guardian if patient is under 18 years of age)