Physical Therapy & Wellness Center

New Patient Information

First Name: _____ Middle Initial: ____ Last Name: _____

DOB: _____ **SSN:** _____ Preferred Name: _____

Address: _____ City: _____ State: _____

Zip: _____ Home Phone: _____ Cell Phone: _____

Which is your primary phone? Home / Cell Would you like Reminders sent to your primary phone? Text / Call

Email: _____

Gender assigned at birth: ☐ Male ☐ Female Gender Identity: _____

Do you have a latex allergy? ☐ **Yes** ☐ **No** Preferred Pronouns: _____

Preferred Language: _____ Any difficulty seeing or hearing? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Doctor: _____ Clinic Name: _____ Date Last Seen: _____

Is this visit due to an accident? ☐ **Yes** ☐ **No**

If yes, please circle: Worker's Compensation Auto Third-Party Liability

How did you hear about us?

☐ Commercial ☐ Radio ☐ Social Media ☐ Friend/Family Member ☐ Doctor ☐ Other: _____

- I hereby authorize Apex Physical Therapy and Wellness Center to provide treatment that will be discussed with me and agreed upon by bother parties following the initial visit or that is authorized by my physician.
- I hereby assign all insurance benefits (or services render to which I am entitled) to Apex Physical Therapy and Wellness Center. I realize that if my third-party payer/insurance company denies my charges or makes partial payment, that I am responsible for the balance.
- I hereby authorize the release of medical records and other pertinent information regarding safe and effective treatment of my condition to Apex Physical Therapy and Wellness Center for the provision of care and for obtaining insurance reimbursement.
- I hereby authorize Apex Physical Therapy and Wellness Center to contact the emergency contact I have listed above if they feel I am unable to make safe and sound decisions.

Does not apply to Worker's Compensation or Auto Accident Patients

- I understand that I am legally responsible for payment to Apex Physical Therapy and Wellness Center for all services rendered. If my insurance is being billed, I will be responsible for any remaining balance (co-insurance) and all co-payments/deductible amounts. I also acknowledge that all co-payments are due at the time of service.

_____ **Please initial that you have received the HIPAA information.**

Due to HIPPA and confidentiality requirements, please read and check the appropriate places.
It is ok to speak with or leave messages regarding my appointments with anyone at/on my:
☐ Home ☐ Cell ☐ Answering Machine
Is there anyone that you do not want us to leave a message with regarding appointments? ☐ No ☐ Yes: _____

Patient Signature: _____ Date: _____

Patient Guardian Signature: _____ Date: _____