

Updated Patient Information

First Name:	M	iddle Initial:	Last Name:	
Is this visit due to an a	accident? 🗆 No	Yes		
If yes, please ci	ircle: Worker's	Compensation	Auto	Third-Party Liability
Have there been any	changes in your	personal informa	ation?	
Personal Insurance: Address: Phone Number: Legal Name:	□ No □ Ye □ No □ Ye □ No □ Ye □ No □ Ye	s s		
Emergency Contact:		Relations	ship:	Phone:
Primary Doctor:		Clinic Nam	e:	Date Last Seen:
 agreed upon by both I hereby assign all in Center. I realize that responsible for the I hereby authorize the my condition to Appendix authorize All hereby auth	ther parties following nsurance benefits (or a t if my third-party payo balance. he release of medical ex Physical Therapy an	the initial visit or that is services render to which er/insurance company records and other per and Wellness Center for	s authorized by my ch I am entitled) to denies my charges tinent information the provision of ca	nt that will be discussed with me and physician. Apex Physical Therapy and Wellness or makes partial payment, that I am regarding safe and effective treatment of are and for obtaining insurance
Does not apply to Worker's • I understand that I a rendered. If my insu	s Compensation or Ai am legally responsible irance is being billed,	uto Accident Patients for payment to Apex	Physical Therapy ar or any remaining ba	nd Wellness Center for all services alance (co-insurance) and all co- t the time of service.
Please initial th	at you have rece	ived the HIPAA in	nformation.	
Due to HIPPA and confidenti It is ok to speak with or leave Home Cell A Is there anyone that you do r	e messages regarding Answering Machine	my appointments with	n anyone at/on my:	
Patient Signature:				Date:
Patient Guardian Signat	ture:			Date: