



OneonOne

Physical Therapy

PATIENT INFORMATION FORM

Today's Date: _____ Date of Injury: _____ State Where Injury Occurred: _____ Condition Related To: _____
(work/auto accident/injury)

Patients Name: _____ Sex: _____ D.O.B.: _____ Age: _____
Last, First, MI mo/day/yr

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Emergency Contact: _____ Emergency Phone: _____
Name, Relationship

Referred by: Web Site: _____ Radio _____ Friend _____ Employer _____ Attorney _____ Physician _____ Other _____

Referring Physician: _____ Phone: _____ Fax: _____

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

METHOD OF PAYMENT

Cash **Check** **Credit Card**

I hereby authorize One-on-One Therapy to furnish information which may be required to process insurance claims for payment of medical services for myself and/or my dependents.

Signature of Responsible Party: _____ Date: _____

One-on-One Therapy strives to provide the highest quality patient care. Clients receive hands-on physical therapy treatment without other clients present for 60 minutes at every visit.

As health care costs continue to rise, One-on-One Therapy makes every effort to maintain our standards of care. In order to honor this commitment, we are an out-of-network provider.

As a courtesy, One-on-One Therapy will file a client's claim with the insurance company. Once the client's deductible is satisfied they will be responsible to pay any co-insurance amount at the time of the visit. The insurance company will be billed for the balance, with the client responsible for any uncovered amounts.

Please call our billing department for questions regarding your insurance coverage. If this is a workers compensation case, we will bill your worker's compensation carrier for your charges.