

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PATIENT INFORMATION**Name: \_\_\_\_\_ Gender: Male ☐ Female ☐ Date of Birth: \_\_\_\_\_  
First MI LastSSN: \_\_\_\_\_ Marital Status: Single ☐ Married ☐ Divorced ☐ Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
P.O. Box Street City State ZipEmployer: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_  
Name Phone #

Email: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

**WHO IS FINANCIALLY RESPONSIBLE?**☐ SAME AS ABOVEName: \_\_\_\_\_ Gender: Male ☐ Female ☐ Date of Birth: \_\_\_\_\_  
First MI LastSSN: \_\_\_\_\_ Marital Status: Single ☐ Married ☐ Divorced ☐ Other: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
P.O. Box Street City State Zip

Employer: \_\_\_\_\_ Email: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**INSURANCE INFORMATION***FOR LIABILITY CLAIMS, PLEASE COMPLETE "ACCIDENT INFORMATION" SECTION BELOW*

Primary Insurance: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Name of Insured: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**ACCIDENT INFORMATION**Injury related to: Employment ☐ Automobile ☐ Other ☐ \_\_\_\_\_ Injury Date: \_\_\_\_\_

Employer/Insured Name: \_\_\_\_\_

Claim #: \_\_\_\_\_

Case Manager: \_\_\_\_\_

Phone: \_\_\_\_\_



## ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge receipt of ProActive Physical Therapy and Sports Rehab Notice of Privacy Practices.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient or Legal Guardian Name (please print)

## CONSENT FOR TREATMENT & INSURANCE INFORMATION RELEASE

I consent to the therapy rendered to me (or the person for whom I am legally responsible) that is determined to be necessary by the therapist.

I authorize you to speak to \_\_\_\_\_ (name), \_\_\_\_\_ (relationship) regarding my account and/or treatment.

I authorize ProActive Physical Therapy and Sports Rehab to contact me via cell phone and/or email regarding appointments or billing inquiries.

Cell phone: ☐ YES ☐ NO

Email: ☐ YES ☐ NO

Permission to leave voicemail: ☐ YES ☐ NO

I authorize ProActive Physical Therapy and Sports Rehab to release any information in the course of my examination and treatment as is required for reimbursement or may be otherwise requested by my insurance carrier, health maintenance organization, other health plan or insurance company representatives/agents. I request my insurance carrier to pay benefits on my behalf to ProActive for any services rendered that are not paid at time of service. I am responsible for the entire bill or balance as determined by ProActive and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services. **I also understand that ProActive Physical Therapy and Sports Rehab collects copayments at time of service.**

**As a courtesy to you, ProActive Physical Therapy and Sports Rehab will bill the insurance carrier listed above. Payment obligation is not contingent on any settlement, claim, judgment, or verdict and we do expect full payment.**

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Date