Patient Information

The Physical Therapy Place

2401 E 42nd Avenue, Suite 103, Anchorage AK 99508

Patient Name			SSN		Date of Birth
Address			Date of Injury or Onset (mm/dd/yy)		How did you hear about us?
City	State	Zip	Medical Providers:		
Home Phone	Mobile Phone		Male ☐	Female ☐	Single ☐ Married ☐ Occupation
Work Phone	E-mail contact		Please complete the *Spouse* or *Parent* information below**, if covered by their insurance**.		
Patient's Employer			Name of Spouse or Parent		Relationship
Address			SSN		Date of Birth
City	State	Zip	Employer		Phone

☐ *Please bill my Primary Insurance* ☐ *Secondary* ☐ *Workman's Comp or Accident* ☐ *I will be paying the bill in full*

PLEASE PRESENT YOUR INSURANCE CARD(S) FOR COPYING

Primary Insurance		Secondary Insurance

***MOTOR VEHICLE** OR **WORKERS COMPENSATION** Patients PLEASE COMPLETE THE FOLLOWING INFORMATION*

CLAIM NUMBER:			Date of Injury/Accident:
Insurance Company Name			Adjustor's Name
Insurance Company Address			Adjustor's Phone
City	State	Zip	Insurance Company Phone

IN CASE OF EMERGENCY, WHOM SHOULD WE CONTACT?

Name	Relationship	Home Phone
Address	City, State, Zip	Cell Phone

***The Physical Therapy Place Cancellation Policy:** There is an $80 charge for NO SHOW appointments. This is the patient responsibility and is not paid by insurance. If you are unable to make your appointment, please call within a 24 hour notice to cancel or reschedule.*

Consent for Treatment: I consent to treatment and authorize the staff of THE PHYSICAL THERAPY PLACE, LLC to render whatever services are necessary for the care of myself and/or my family member.

SIGNATURE: ***DATE:***

Medical Release: I hereby authorize the release of medical information to my insurance carriers concerning my condition and treatments. I hereby assign The Physical Therapy Place, LLC payments for medical services rendered to myself and my dependents.

SIGNATURE: ***DATE:***