



## Updated Patient Information

*"Keeping you in peak health!"*

Are there any changes in your personal information?

Insurance:      No      Yes      \_\_\_\_\_  
Address:        No      Yes      \_\_\_\_\_  
Phone Number: No      Yes      \_\_\_\_\_  
Name:           No      Yes      \_\_\_\_\_

Last date seen by physician: \_\_\_\_\_

- I hereby authorize Apex Physical Therapy and Wellness Center personnel to provide treatment that will be discussed with me and agreed upon by both parties following the initial visit or that is authorized by my physician.
- I hereby assign all insurance benefits (or services rendered 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.

**\*\*Does not apply to Worker's Compensation or Medicare 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 (green form).

Due to HIPAA 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      Work      Answering Machine

Is there anyone that you do not want us to leave a message with regarding appointments?

No      Yes, please list: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Patient Guardian Signature: \_\_\_\_\_  
(If applicable or patient under age 18)