New Patient Information Form

Patient Name: ______________________ DOB: ____________ Age: ________

Address: ______________ City: ________________ State:________ Zip: ________

Male ________ Female __________ Driver's License #/SS #: ______________________

Home Phone: ______________ Cell Phone: ____________________ Work Phone: ______________

Email Address: ____________________________________

Text reminders: Y N or Call reminders: Y N

What phone should we send reminders to? Home Cell

Emergency Contact & Relation: __________________________ Phone: ______________

Do you have a latex allergy? Y N

How did you hear about us?
TV Commercial Radio Social Media Friend/Family Member Doctor Other______________

Method of Payment:
Cash
Private Insurance
Medicare
Secondary Insurance? Yes No
Name of Insurance: __________
Workforce Safety
Other________________

Primary Care Physician: ______________
Primary Care Clinic: ____________
Last date with 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.
- I hereby authorize Apex Physical Therapy and Wellness Center to contact the emergency contact I have listed above if they feel I am unable to make safe and sound decisions.

Does not apply to Worker's Compensation or Auto Accident 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.

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 Signature: ________________________________

Patient Guardian Signature: ____________________________