

**Name: (First): (M.I.): (Last):**

**Street Address: Apt. #**

 **City: State: Zip: SSN:**

**Date of Birth: Age: Sex:**

**Home Phone: Cell Phone:**

 **Okay to leave message. \_\_\_ Yes \_\_\_ No**

**E-mail Address:**

**How would you like appointment reminders: \_\_\_ Call \_\_\_ Text \_\_\_ Email \_\_\_\_\_\_**

 **Other Person to Contact in Case of Emergency:**

**Phone Number: Relationship:**

**Primary Care Dr. Phone:**

**How did you hear about us: \_\_\_\_\_ MD \_\_\_\_\_ Internet \_\_\_\_\_ Family/Friend \_\_\_\_\_ Other**

**Payment Source: Private Insurance Workers Compensation**

 **Self-Pay Auto Insurance Carrier:**

**ID/Claim #: Secondary Insurance:**

**ASSIGNMENT OF BENEFITS: I understand that I am responsible for all charges weather or not they are paid by my insurance. I authorize Advanced Physical Therapy & Ergonomics, Inc. to release any information necessary to secure payment of benefits. I authorize my insurance benefits to be paid directly to Advanced Physical Therapy & Ergonomics, Inc. I understand that payment for service is expected at time service is rendered unless my insurance is to be billed. Advanced Physical Therapy & Ergonomics, Inc. will gladly help obtain insurance coverage information and referrals for you. However, I understand that it is my responsibility to know the coverage and benefits of my insurance plan.**

 **Print Name Signature Date**