AXIS PT

Orthopedic, Manual and Sports
Physical Therapy

Patient Information

Patient's Name:_____E-mail:_____

Home Address:_____APT/UNIT#_____

City:_____State:_____Zip code:_____

Home phone #_____Cell#_____Date of Birth:_____

Please circle one: **MALE FEMALE NON-BINARY**

Marital Status: **SINGLE MARRIED PARTNER DIVORCED WIDOWED MINOR**

Spouse's/Guardian's Name: _____

Employment Information

Employer's Name:_____ Occupation:_____

Address:_____ Work phone #:_____

In case of Emergency, please contact:

Name:_____Relation:_____

Home phone #_____Work#:_____Cell#_____

Physician Information

Name of referring doctor:_____Phone #_____

How did you hear about us? Yelp___Friend___Name of friend_____Doctor_____Attorney_____Other:_____

Payment Information

Circle One: Lien Insurance Cash Worker's Compensation

If this is Worker's Compensation, do you have an attorney? YES NO

If yes, we need the attorney's name, address and phone number(s):_____

***No-Show/Cancellation policy:* I understand there will be a charge of $75 for any no-show and $50 for a late cancellation of appointments with less than 24 hours' notice.**

Financial Responsibility: I am financially responsible for all charges incurred at AXIS PT, INC. Any portion of these charges not covered by my insurance company must be paid by me. I further understand that all insurance deductibles are my responsibility and any deductible applied to AXIS' charges will be paid directly by me to AXIS PT, INC.

Patient's signature:_____Date:_____

Assignment of Benefits: I hereby authorize my insurance benefits to be paid directly to AXIS PT, INC.

Patient's signature:_____Date:_____

Authorization to release information: I authorize AXIS PT to release any information required by my insurance company.

Patient's signature:_____Date:_____

Please Note: If you are a member of a managed care insurance, HMO, PPO or POS, it is your responsibility to know your policy provisions and inform this office.