AXIS PT

Orthopedic, Manual & Sports
Physical Therapy

Patient Information

Patient's Name:_____

Home Address:_____

City:_____State:_____Zip code:_____E-mail:_____

Home phone #_____Cell#_____Date of Birth:_____

Spouse's/Guardian's Name:_____Date of Birth:_____

Employment Information

Employer's Name:_____

Address:_____

Work phone #:_____Occupation:_____

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: _____ ☐ Doctor: _____

☐ Attorney:_____ ☐ Other:_____

Payment Information

Check 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 $60 for any no-show and $40 for a late cancellation of appointments with less than 24 hours' notice *(PLEASE CALL TO CANCEL DO NOT EMAIL).

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.

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