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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT INFORMATION | | | | | | | | | | |
| First Name | M.I. | Last Name | | | Date of Birth | Social Security Number | | | | Male  Female |
| Home Address | | | | City | | | | State | Zip Code | |
| Referring Physician | | | Marital Status | | | | Home Phone  ( ) | | | |
| Employment Status | | | Employer/School Name | | | | Work Phone  ( ) | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| EMERGENCY CONTACT INFORMATION | | | | |
| First Name | M.I. | Last Name | | Relationship |
| Home Phone  ( ) | | | Day Phone  ( ) | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| RESPONSIBLE PARTY INFORMATION  (If patient is a minor) | | | | | | |
| First Name | M.I. | Last Name | | Relationship | | |
| Address | | | City | | State | Zip Code |
| Home Phone  ( ) | | | Work/Day Phone  ( ) | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| REASON FOR TODAY’S VISIT | | | |
| Part of the Body | Date of first Symptoms / Injury | Was this a motor vehicle accident? | On the job injury? |
| Briefly describe your symptoms / accident or injury/ illness: | | | |

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| --- | --- |
| RESPONSIBLE PARTY STATEMENT | |
| As the responsible party, I hereby assign all medical benefits to which I am entitled to PHENIX Physical Therapy & Personal Wellness in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to, collection service fees, attorney’s fees and all court cost and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of PHENIX Physical Therapy & Personal Wellness as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence. | |
| Responsible Party | Date |

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