DynamX Physical Therapy

Patient Information

Name:_____ Date of Birth:_____

Address (*Street, City, State, ZIP*) _____

Home Phone: _____ Cell Phone:_____ Work: _____

Email:_____ Social Security #_____

Referring MD: _____ Tel # _____

Primary MD: _____ Tel # _____

Employer (*If Worker's Compensation*): _____ Tel # _____

Primary Insurance: _____ Member ID_____

*Guarantor / Policy Holder:*_____ *Date of Birth:*_____

Secondary Insurance: _____ Member ID_____

*Guarantor / Policy Holder:*_____ *Date of Birth:*_____

Emergency Contact: _____ Tel # _____

If Patient is under the age of 18 or unable to make decisions on their own:

Parent/Guardian: _____ *Relationship:* _____

Home Phone: _____ *Cell Phone:*_____ *Work:* _____

Does DynamX Physical Therapy have permission to treat the patient and bill the patient and their insurance of services rendered? _____ *Yes* _____ *No*

Parent/Guardian Signature: _____

Please Read, Initial and Sign Below

_____ **The information above is accurate**

_____ **I received and have reviewed a copy of DynamX Physical Therapy's HIPAA Policy**

_____ **I consent to treatment by DynamX Physical Therapy and their staff/agents**

_____ **I allow DynamX Physical Therapy to bill my insurance for services received and understand that I will be responsible for any unpaid balance.**

Patient/Guardian Signature:_____**Date**:_____

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