PETTYGROVE PHYSICAL THERAPY & SPORTS REHABILITATION
1515 N.W. 18TH AVE. / SUITE 400 / PORTLAND, OREGON 97209
PHONE: 503.228.1306 // FAX: 503.228.1307

PATIENT INFORMATION:

LEGAL NAME:_____ DATE OF BIRTH:_____ AGE:_____
last first middle initial month/day/year

ADDRESS:_____
street city state zip code

PHONE:_____
home work cell

EMERGENCY CONTACT: _____ PHONE: _____
name
RELATIONSHIP:_____

PATIENT'S SSN: _____ (___Male) (___Female) (___Single) (___Married) (___Widowed) (___Divorced) (___Other)

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EMPLOYER INFORMATION OCCUPATION:_____

EMPLOYER: _____ EMPLOYER ADDRESS:_____
street / po box
PHONE: _____ _____
work city state zip code

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PHYSICIAN INFORMATION
PRIMARY CARE DOCTOR: _____ PHONE:_____

REFERRING DOCTOR: _____ PHONE: _____

DID YOU HAVE SURGERY FOR THIS CONDITION? **____* YES ____NO (* IF YES, DATE OF SURGERY:_____)**

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IS THIS CONDITION RESULT OF AN INJURY? _____ MVA OR _____WORK RELATED DATE OF INJURY:_____
_____ * YES _____ NO (* IF YES, IS IT:) AUTO -> CLAIM # _____
WORK -> CLAIM #_____
IS YOUR CLAIM: _____ OPEN _____ DEFERRED _____ DON'T KNOW
INSURANCE CARRIER: _____
ADJUSTER'S NAME: _____
ADJUSTER'S PHONE: _____ EXT. _____

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PRIVATE INSURANCE INFORMATION ***(PLEASE FILL IN INFORMATION "ONLY" IF YOU DO NOT HAVE YOUR CARD WITH YOU)***
PRIMARY CARRIER: _____ PHONE: _____
POLICY/ID NUMBER: _____ GROUP NUMBER: _____ GROUP NAME: _____
INSURED'S NAME: _____ INSURED'S SSN: _____
SECONDARY CARRIER: _____ PHONE: _____
POLICY/ID NUMBER: _____ GROUP NUMBER: _____ GROUP NAME: _____
INSURED'S NAME: _____ INSURED'S SSN: _____

ASSIGNMENT FOR INSURANCE BENEFITS AND AGREEMENT TO PAY: In consideration for services rendered, I hereby authorize payment to the physical therapist or supplier. In addition, I authorize the release of any medical information necessary to process this claim. I agree that should the amount be insufficient to cover the entire expense, I will be responsible for the unpaid amount, and any charges not covered by said policy, I will be responsible for payment of the entire bill.

MEDICAL BENEFICIARIES: The $1500 maximum benefit for physical therapy and speech does not apply to all facilities. For more information please contact your physician.

WAIVER: If a referral has not been received from my primary care physician for my visit today, or if there is a question if the referral is valid, or if the service is not covered benefit, I accept financial responsibility for the total payment. I also understand I am responsible for obtaining an original or retroactive referral for processing of a medical claim. In addition, if my insurance carrier is not contracted with Pettygrove Physical Therapy, I accept financial responsibility for all charges not covered by my healthcare company.

CONSENT FOR CARE AND TREATMENT: I, the undersigned, do hereby agree and give my consent for Pettygrove Physical Therapy to furnish medical treatment considered necessary and proper in diagnosing or treating a diagnosed physical condition.

Patient Signature: _____ Date: _____