Borger Physical Therapy

Patient Information

First Name:_____ Last Name:_____ Nick Name:_____

Date of Birth:____/____/____ Social Security Number:____-____-____ Male □ Female □

Address / PO Box:_____ City, State, Zip:_____

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

E-Mail Address_____ **Text appoinment reminder- Cell phone Carrier**_____

Employer:_____ Phone:_____Occupation:_____

Name of Spouse:_____ Date of Birth:___/___/___ Employer:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Financial Responsibility (Person Financially Responsible for Patient Named Above)

First Name:_____ Last Name:_____ Date of Birth:____/____/____

Address / PO Box:_____ City, State, Zip:_____

Social Security Number:_____ Relationship to Patient:_____

Health Insurance Information: (Primary) *Must have photocopy of card*

Insurance Name:_____ Relationship to Insured: Self □ Spouse □ Child □ Other □

Name of Insured:_____ SS # _____ Date of Birth:____/____/____

Deductible Amount:_____ Amount Met:_____ Co-Pay Amount:_____

Health Insurance Information: (Secondary)

Insurance Name:_____ Relationship to Insured: Self □ Spouse □ Child □ Other □

Name of Insured:_____ SS # _____ Date of Birth:____/____/____

Deductible Amount:_____ Amount Met:_____ Co-Pay Amount:_____

Referring Physician

Referring Physician: _____

Primary Care Physician

Primary Care Physician:_____

Phone #:_____

Medicare Patients (please complete)

Have you ever had Home Health Care? Yes ☐ No ☐ If yes, dates seen:_____to_____

Name of Home Health Care Facility:_____Phone:_____

Automobile Accident / Worker's Compensation (please complete)

Name of Insurance Company:_____ Date of Accident:____/____/_____

Address:_____City, State, Zip:_____

Phone #:_____ Claim #:_____ Adjuster Name:_____

Please Complete

You ***must*** have a prescription for physical therapy from your physician. Do you have one with you now? Yes □ No □

Date of injury or first noticed pain:____/____/____ and/or date of surgery ____/____/____ Return to physician___/___/___

Have you had Physical Therapy in the past ? YES NO If yes, when?___/___/____ where_____ how many visits_____

Have you contacted your insurance company about receiving physical therapy and your required copay's? Yes □ No □

Does your insurance company require a referral from your primary care physician to go to a specialist? Yes □ No □

Consent for Treatment I hearby consent to such treatment procedures and patient care which, in the judgement of my therapist and/or physician, may be considered necessary or advisable while a patient of William R. Myers, dba Borger Physical Therapy. I also agree the release of any private health information necessary to process claims and authorize the payment from any benefit program be made directly to William R. Myers. I, the undersigned agree, am financially responsible for any deductibles, copays and/or any charges not covered by insurance.

Signature:_____ ***Date:***____/____/_____

(Insured and/or Responsible Party)

For Office Use Only:
