Pediatrics Patient Information Form - Private and Confidential

Patient Demographics

Name:* Last Name

First Name

Middle Initial

Date of Birth:* **Gender:***

Social Security Number: (Optional)

Home Address:*

City:* **State:***

Zip:*

Billing Address:*

City:* **State:***

Zip:*

Patient's Physician:*

Do you have a follow up appointment scheduled?: *

- ○ **Yes, Date of appointment:** mm/dd/yyyy
- ○ **No, I am to call the doctor to schedule a follow up.**
- ○ **No, doctor did not request to see me again**

How did you hear about Eagle Physical Therapy?

- ☐ **Physician**
- ☐ **Advertising**
- ☐ **Friend/Family**

Whom?:

Parent or Guardian #1

Name:*

Phone Number:*

Employer:*

Date of Birth:* mm/dd/yyyy

Social Security Number: (Optional)

Email:*

Parent or Guardian #2

Name:

Phone Number:

Employer:

Date of Birth: mm/dd/yyyy

Social Security Number: (Optional)

Email:

Closest Relative or Friend (not living with you):

Name: *

Address: *

City: **State: ***

Phone Number: *

What are your goals for physical therapy?:

INSURANCE INFORMATION:

Primary Insurance:		**Secondary Insurance:**	
Subscriber:		**Subscriber:**	
ID#:		**ID#:**	
Group#:		**Group#:**	
Address:		**Address:**	
Phone:		**Phone:**	

Eagle Physical Therapy is committed to providing quality physical therapy at reasonable cost. It is our policy to collect all accounts receivable within 90 days from date of service.

For those patients with insurance coverage, we bill regularly. The patient retains ultimate responsibility for financial charges incurred as a result of treatment. Our staff is available for assistance with insurance billing questions. ***However, the patient is responsible to understand the specifics of their individual insurance coverage. The insurance contract is between the covered individual and the insurance company.***

☐ I hereby consent to such physical therapy procedures as may be rendered by Eagle Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Eagle Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. A $25.00 fee will be charged for returned checks. Eagle Physical Therapy has the authority to disclose medical information for treatment, payment and health operations. Eagle Physical Therapy is released from disclosure of the patient's records as provided by this paragraph. *

☐ I acknowledge that I have been informed and notified of the whereabouts of Eagle Physical Therapy's notice of information practices (how medical information regarding myself/child may be used and disclosed and how I can get access to this information). *

Patient/Guardian's Initials:* **Date:**