EXPERIENCE EVERY DAY.

Alpine Physical Therapy & Spine Care

Last Name _____ First Name _____ MI _____ Nickname/Preferred Name _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____ E-Mail _____

Primary Phone _____ Secondary Phone _____ Work Phone _____

Employer Name and Address _____

Emergency Contact _____ Relationship to Patient _____ Phone Number _____

How did you hear about APT? Who referred you to our office?_____

Your benefits may be affected by previous treatment elsewhere (visit limits, authorizations, etc) Please note the number of physical therapy visits you've had this year at any other locations: _____

If patient is under age 18, please complete the following:

Name of Parent or Guardian _____ Parent or Guardian SSN _____ Parent or Guardian Date of Birth _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Work Injury / Accident Information, please complete the following if applicable:

Accident Date _____ Claim Number _____ Accident Insurance Co. _____

Address _____ Adjuster Name _____ Adjuster Phone _____

Attorney Name & Phone Number, if applicable _____

- - FOR OFFICE USE ONLY - -

Verification Date _____ Insurance _____ Phone _____

Policy/ID Number _____ Group Number _____ Effective Date _____ Auth Required _____

Deductible (met) _____ Coverage/Co-pay _____ Visit Limits _____ Visits Used YTD _____

Authorization/Coverage/Exclusion Details: _____

My health information may be created or received by Alpine Physical Therapy (APT) and may be in the form of written or electronic records, or spoken words. My health record may include information of my health history, health status, test results, diagnoses, treatments, procedure, prescriptions, and similar types of health-related information.

I understand that I have the right to receive and review a written description of how Alpine Physical Therapy will handle my health information. The written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and practices followed by the employees, staff and other office personnel of APT and my right regarding my health information. You may view our Notice of Privacy Practices on our website: alpinephysicaltherapy.com.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or summary of the most current version of APT's Notice of Privacy Practices in effect will be available at our front desk and on our website.

By signing, I agree that I have reviewed and understand the above information and that I am entitled to have a copy of APT's Notice of Privacy Practices if I so choose. Please inform the staff and they will supply you with a copy.

Patient's Name (please print) _____ DOB: _____

Patient's Signature _____ Date _____

SPECIAL PERMISSION REQUEST

I give my permission for Alpine Physical Therapy to leave messages regarding appointments, billing, and medical information on any of the following numbers: _____

_____

Patient's Signature _____ Date _____

I give my permission to share health information with: _____

Relationship: _____

Patient's Signature _____ Date _____

This release will be revoked by written permission only. I understand that I must send a written request to Alpine Physical Therapy in order to revoke this release.

Patient's Signature _____ Date _____