SHELBYVILLE PHYSICAL THERAPY AND SPINE CARE CENTER, P.S.C.

PATIENT INFORMATION: (*Please Print*) **Date:**

First	Middle	Last	Social Security Number:
Name:			

Address: | **Birthdate:**

City: **State:** **Zip code:** | **Sex:** | **Age:** | **Race:**

Home Phone: ( ) **Work Phone: ( )** | **Marital Status:**

Cell Phone: ( )

Employer: **Address:**

Emergency Contact (*not living with you*): | **Phone:**

Billing information: (*Please complete if other than patient or if patient is under18*)

First	Middle	Last	Relation to patient
Name:			

Address: | **SS#:**

Home Phone: ( ) **Work Phone: ( )** | **Birthdate:**

Employer: **Address:**

INSURANCE INFORMATION: (*Please present insurance card so a copy can be made*)

Primary Insurance: **Address:** **Subscriber:**

Secondary Insurance: **Address:** **Subscriber:**

Auto Accident: _____ yes _____ no **Date of accident:**
Worker's Comp: _____ yes _____ no **Date of accident:**

Referring physician:

How did you first learn of our facility? _____

Was this a factor in choosing our facility? _____

PLEASE READ CAREFULLY AND <u>INITIAL</u> each space below:

_____ **Permission is hereby granted to Shelbyville Physical Therapy& Spine Care Center, P.S.C. to release information to my attorney, insurance company, worker's compensation carrier, referring physician/personal physician.**

_____ **Permission is hereby granted to release medical records to Shelbyville Physical Therapy & Spine Care Center, P.S.C.**

_____ **I assign payment of medical benefits directly to Shelbyville Physical Therapy & Spine Care Center, P.S.C. for services rendered.**

_____ **I understand that as a patient of Shelbyville Physical Therapy & Spine Care Center, P.S.C. there may be treatments and/or supplies required that are not covered by my insurance. In that event, I understand that I would be liable for those charges.**

_____ **Should collection and/or legal action be needed to collect my debt to Shelbyville Physical Therapy & Spine Care Center, P.S.C., I understand that I am responsible for those charges.**

_____ _____

Signature **Date**