COLUMBIA PHYSICAL THERAPY
Pasco, WA

**For official use only:**
Physical Therapist:_____
Diagnosis Code:_____

Patient's Name:_____ Primary Phone #:_____

Address:_____ Email:_____

City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Sex: ☐ Male ☐ Female S.S. #:_____

Employer:_____ Where did you hear about us?:_____

Employer address:_____ City:_____ State: _____ Zip Code:_____

Referring Physician:_____ Physician's address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

***If Married*:** Spouse's Name:_____ Employer:_____

Home Phone:_____ Work Phone:_____ S.S. #:_____

***PLEASE COMPLETE IF PATIENT IS A MINOR:***

**Mother/Guardian's name:**_____ Address:_____

City:_____ State:_____ Zip Code:_____ S.S. #:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

**Father/Guardian's name:**_____ Address:_____

City:_____ State:_____ Zip Code:_____ S.S. #:_____

Employer:_____ Address:_____

City:_____ State:_____ Zip Code:_____ Phone #:_____

***INSURANCE INFORMATION*: Please present the front office with insurance cards**

**Primary Insurance Carrier's Name:**_____ Address:_____

Subscriber's Name:_____ Employer Name:_____

Subscriber's ID #:_____ Group #:_____ Date of Birth:_____

**Secondary Insurance Carrier's Name:**_____ Address:_____

Subscriber's Name:_____ Employer Name:_____

Subscriber's ID #:_____ Group #:_____ Date of Birth:_____

**Is treatment a result of a:** ☐ On the job injury ☐ Auto ☐ Accidental

Date of Injury:_____ Claim #:_____

Emergency Contact (Not living with you): Name:_____ Phone:_____

I authorize Columbia Physical Therapy, Inc. P.S. to use and disclose health and medical information for the purposes of treatment, payment and health care operations. Under all circumstances I assume final responsibility for my account understanding that in the event my account becomes delinquent, I agree to pay accrued finance charges, court costs and attorney fees. I consent to physical therapy services prescribed by any physician. I authorize payment of medical benefits by my insurance company to Columbia Physical Therapy, Inc. PS, for services rendered. I have received this practice's Notice of Privacy Practices written in plain language.

Signature:_____ Date:_____