Patient Information:

Idaho Physical Therapy

Patient Name: _____

☐ Male ☐ Female ☐ Married ☐ Divorced ☐ Widowed ☐ Single

SSN: _____ Date of birth: _____

Address: _____

Phone: (home) _____ (cell) _____ (other) _____

Emergency contact name: _____

Relationship to patient: _____ Emergency contact phone: _____

If the Patient is under 18:

Parent/guardian's name: _____

Parent/guardian's DOB*: _____ Parent/guardian's SSN*: _____

**We need this information to bill insurance.*

I would like appointment reminders sent to me via (please pick ONE):

☐ Email: Please list email. _____

☐ Text message: Please list phone number & carrier (Verizon, T-Mobile, Sprint, etc). The reminder cannot be sent without the carrier information. _____

☐ I would not like appointment reminders.

Insurance Authorization:

I hereby consent to such medical procedures as may be rendered by Idaho Physical Therapy. I authorize Idaho Physical Therapy to release to my insurance company and its agents any information needed to determine my benefits or the benefits payable for related services. I authorize Idaho Physical Therapy to bill my insurance carrier for services rendered, and I authorize for all insurance benefits (including Medicare and/or Medicaid, if applicable) to be paid directly to Idaho Physical Therapy on my behalf. In addition, I assume financial responsibility for the balance of charges not included in my insurance coverage.

Patient Signature _____ Date _____

Parent Signature (if Patient is under 18) _____