



MOUNTAIN VALLEY
PHYSICAL THERAPY

Therapist:
Date of First Appointment: / /

PATIENT INFORMATION FORM

Patient Name:	Date of Birth: / /	Male or Female
Patient Address:		
Home Phone:	Work Phone:	Cell Phone:
Employer:	Social Security:	
Emergency Contact Name & Phone: <small>(SOMEONE NOT LIVING WITH YOU)</small>		
Email:		

MEDICAL INFORMATION

Referring Doctor:	UPIN#{mc}:	Phone:
Diag.:	ICD9 code:1:	2: 3: 4:
Date of Injury:	Date of Surgery:	

BILLING INFORMATION

Insurance Type:	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Medicare	<input type="checkbox"/> Auto	<input type="checkbox"/> Priv Ins	<input type="checkbox"/> HMO	<input type="checkbox"/> PPO
Insurance Company:	Adjustor:					
Phone:	Fax:					
Address:						
Group/Claim #:	Policy ID:					
Name of Insured:	Insured's Birthday: / /	Male or Female				
Relationship to Insured:	Insured's Employer:					
Authorization or Referral #:	# Visits Authorized:					
Secondary Insurance:	Phone:					
Address:						
Group #:	Policy ID:					
Name of Insured:	Insured's Birthday: / /	Relationship:				

- I authorize the release of information necessary to process my insurance claims and for payment to be made directly to: Mountain Valley Physical Therapy
- I agree to pay all co-payments required, deductibles and any portion that my insurance will not pay
- If this account goes to collections, I will be responsible for all fees incurred
- A \$5 monthly rebill charge is added to patient balances which are 30 days past due
- A \$25 fee will be added for any returned checks

Signature:	Date:
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