FYZICAL Therapy & Balance Centers of Rockville

Patient Information Form (*Please Print*)

Patient Name:_____

Date: _____/_____/_____

Have we seen you before? _____Yes _____No

Approx. When? _____ Issue?_____

Maiden Name: _____

Patient Address: _____

City: _____State _____Zip _____

Date Of Birth: _____/_____/_____

Phone (H) _____

(W) _____

(C) _____

Marital Status: *(Please circle one below)*

Married | Single | Widow | Divorced

Sex: Male | Female

Date of Injury/Onset: _____/_____/_____

Date of Surgery: _____/_____/_____

Email Address: _____

Referring Physician: _____

Primary Physician: _____

Emergency Contact: ***(please fill out below)***

Name: _____

Phone:_____

Patient's Occupation: _____

Patient's Employer: _____

If the patient is not the primary subscriber on the insurance account, please complete next 3 lines

Insured's Name: _____ Insured's Date Of Birth: _____/_____/_____

Insured's Employer:_____

Insured's Employer Address: _____

____I have received and read the notice of Privacy Practices and was offered a copy.

____I am aware of the **$75 cancellation fee without notice** provided by 2pm on the business day prior to the appointment.

I CERTIFY that the information I have given above is correct and I authorize the release of any necessary information to my insurance company. I permit a copy of the authorization to be used in place of the original and I authorize this signature to be used when processing claims. I may revoke this in writing anytime.

I HEREBY assign Seneca Physical Therapy, Inc., dba FYZICAL Therapy & Balance Centers of Rockville, all payments rendered for my dependent or myself. If my current policy prohibits direct payment to Seneca Physical Therapy, Inc., dba FYZICAL Therapy & Balance Centers of Rockville, or if my bill becomes delinquent (over 90 days past due), I understand and agree that I am responsible for paying all charges including co-payments and co-insurance, PLUS finance charges in the amount of 1.5% per month on the unpaid balance, reasonable collection fees and/or attorney fees, and court costs. In addition, I authorize Seneca Physical Therapy, Inc., dba FYZICAL Therapy & Balance Centers of Rockville, to initiate a complaint to the insurance commission for any reason on my behalf.

Signature: _____ Date: _____

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