1219 South Main Street
Palmyra, MO 63461
Phone: 573-769-6166
Fax: 573-769-2356

2521 South Cashua Drive
Florence, SC 29501
Phone: 843-536-4888
Fax: 843-799-0992

PLEASE PRINT AND COMPLETE ENTIRE FORM

Patient Name: _____ Social Security #: _____
(Last) (First) (Middle)

Address: _____ City _____ State _____ Zip _____

Home Phone: (____) _____ Cell Phone (____) _____ Date of Birth ____/____/____

E-mail address: _____ Employer: _____

Work phone: (___) _____ Job Description: _____

Marital Status: M S D W *Spouse Name:* _____ *Spouse Social Security #* _____

Spouse Date of Birth ____/____/____ *Spouse Employer* _____ *Spouse Work Phone* (____) _____

If patient is a minor, please give parent/guardian name: _____

Parent/Guardian Employer: _____ *City* _____ *State* _____ *Zip* _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP TO THE PATIENT: _____ EMERGENCY CONTACT PHONE: (____) _____

How did you hear about Priority Physical Therapy? _____

Do you wish to receive appointment reminders? ☐ No, thank you ☐ Yes, via e-mail ☐ Yes, via text message

Have you or do you plan to retain a lawyer? ☐ Yes ☐ No

INSURANCE INFORMATION AND RELEASE OF MEDICAL INFORMATION

Primary Insurance: _____ Secondary Insurance: _____

Policyholder Name and DOB: _____

I authorize direct payment from my insurance carrier(s) to Priority Physical Therapy for medical services rendered to me. I also understand that I am financially responsible for all charges regardless of my insurance coverage. I authorize the disclosure and release of my medical information and records according to the Notice of Privacy Act. I authorize Priority Physical Therapy to furnish medial care and treatment as prescribed by my physician.

_____
Signature *Date*

FINANCIAL AGREEMENT: ***I agree and promise to pay the charges incurred for services provided to the patient, and all cost incurred in the collection of same, including reasonable attorney fees if applicable.***

_____
Signature ***Date***

If treatment is due to a motor vehicle accident or other injury/accident or other liability claim, please indicate where claim/billing should be sent:

WORKERS COMPENSATION: If you were hurt at work, you will need to complete an additional questionnaire.

Therapist Signature: _____