Patient Information

First Name_____ Last Name_____ Date of Birth_____

Height:_____ft._____in. Weight:_____. Email:_____

SS#_____ Phone #_____ Cell #_____

Interpreter:_____Phone Number:_____.

Appointment reminder by (please circle one) : ☐ text ☐ call ☐ none

Address_____ City_____ State____ Zip_____

Employer_____ Work #_____

Referring Doctor_____ Phone #_____

Primary Care Doctor_____ Phone #_____

Emergency Contact Name:_____Phone #_____.

Body Part Being Treated (please note which side of the body) _____
Date of Injury or Onset of current symptoms (_____
Is this a Work Injury? ___Yes ___No Is this an Auto Accident? ___Yes ___No
Where did you hear about Valley Rehab Physical Therapy? _____

Insurance Information

WORK INJURY: Labor & Industries/Self Insured Company_____
Claim Number_____

OTHER (Please provide front desk with insurance card)
Primary Insurance Company_____ Member ID#_____
Primary Insured's Name_____ Primary Insured's DOB _____
Secondary Insurance Company_____ Member ID#_____
Secondary Insured's Name_____ Secondary Insured's DOB _____

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Valley Rehab Physical Therapy regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.
*Patient/Parent/Guardian Signature: _____ Date: _____

I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.
*Patient/Parent/Guardian Signature: _____Date:_____