

ADVANCED TRAINING AND REHAB

Physical Therapy and Sports Specific Fitness Training

Name: _____ Date of Birth _____
Last First Middle Initial
Gender: M F Marital Status: _____ SS#: _____

Email address: _____

Address: _____ Home Phone: _____
(street)

(city, state, zip code) Cell Phone: _____

Parent/Guardian: _____ DOB: _____ Work Phone: _____
** (if under age 18)**

Emergency Name and Contact #: _____

Employer's Name/Address: _____

Occupation: _____ Referring Doctor: _____

How did you hear about Advanced Training & Rehab? _____

WORKERS COMP, AUTO, OR ATTORNEY INFORMATION

____ Non-Applicable

Name _____ Injury: _____ Work _____ Other _____
Employer, Company or Attorney _____ MVA Accident _____
Date of Injury/Onset ____/____/____
Address _____ Off Work Dates: From ____/____/____

To ____/____/____
Contact Person _____

INSURANCE INFORMATION

Have you had any visits to a Physical Therapist or Chiropractor this year? Y N

If so, how many visits? _____

Primary Insurance _____ ID# _____ Grp # _____
Insured's Name _____ Employer _____
Relationship to Insured _____ DOB _____

Second Insurance _____ ID# _____ Grp# _____
Insured's Name _____ Employer _____
Relationship to Insured _____ DOB _____

By my signature below, I authorize Advanced Training And Rehab to treat me. I understand I have the right to refuse this treatment. All medical expenses shall be my responsibility. I Agree to pay any additional charges related to the cost of collection (including but not limited to finance charges, interest, collection agency fees of 40% of the bill that are added to the total bill, reasonable attorney's fees and court costs). I authorize Advanced Training And Rehab to release any medical information necessary for the processing and payment of my bills to any insurance company or other third-party payer who is or may be responsible for paying for medical treatment. I further authorize release of copies to the referring physician or physicians consulted in regard to said treatment. I further authorize the use of said records for the purpose of Workmen's Compensation disclosure. I hereby assign, transfer, and set over to Advanced Training And Rehab all of my rights, title and interest to my medical reimbursement benefit under my insurance policy.

SIGNATURE _____
Patient or parent/guardian of minor child

DATE _____