inmotion
PHYSICAL THERAPY

New Patient Form

Name: ________________________________Today's Date: _______________________________

Current Address: ____
Street City State Zip

Other Address: ____
Street City State Zip

Day Phone: __________________ Mobile Phone: ________________Work:__________________

Social Security #: ______________ Date of Birth: __________ Email Address:________________

Primary Insurance Company: ___________________________ ID#: ______________________
Group #: __________________ Primary Insured Name: ____________________ DOB: __________
Secondary Insurance Company: _________________________ ID#:_______________________

Group #: __________________ Primary Insured Name: ____________________ DOB:__________

Referring Physician: __________________Date of LAST and NEXT appointment:_______________

In case of an emergency, Notify: ____

Who may we thank for referring you to us? ____

Consent to Treat and Authorize to Release Information

Initial:

_____ I consent to evaluation and treatment by In Motion Physical Therapy and realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

_____I authorize the release of information acquired in the course of my treatment, including, but not medical records, electronic media, and oral communication, to my insurance company representatives, primary care physician, and/or third party payer.

_____I authorize phone messages regarding my treatment and appointments to be left with persons or machines at the phone numbers I have provided.

_____To optimize our ability to accommodate our patients it is our policy that cancellations must be provided 24 hours in advance otherwise a $30 fee will be collected.

Patient's Signature ____Date ________________