FOX VALLEY PHYSICAL THERAPY NEW PATIENT QUESTIONNAIRE

Referring Doctor: _____

Patient Name:_____
LAST FIRST MI

Address: _____
City/zip code

Home Phone ( ) _____-_____Work Phone_____-_____Cell Phone _____

Date of Birth: _____ SEX: M F Marital status: S M D W

E-Mail Address:_____Date of injury:_____

Emergency Contact:_____ Phone #_____
Name and relationship

Patient's Employer:_____ Contact person:_____

Employer Address:_____ Employer Phone #_____

CIRCLE WHO IS TO BE BILLED: SELF WORK COMP LEGAL/ACCIDENT INSURANCE OTHER

***Cardholder's Date of Birth*: _____**

Insurance Co.:_____ Policy # _____ Phone # _____

****Occasionally equipment and/or supplies are given to you that are not covered under your insurance plan and therefore you are responsible for payment. Please remember that <u>you</u> are financially responsible for the services rendered. Patients are responsible for their co-payment and deductible amounts.**

Would you want progress notes sent to your rehabilitation specialist or any other physicians other than your referring physician? If so, please sign in the space provided. _____
Signature

Patient or authorized person's signature. I authorize the release of any medical information necessary to process this claim. I authorize payment directly to Fox Valley Physical Therapy and Wellness Clinic, Inc. for physical therapy services rendered. I understand that I am financially responsible for charges not covered or reimbursed by third party payers, (Medicare, group/private insurance.)

Signed :_____ Date:_____

Please answer the following questions:

Are you aware that physical therapists can evaluate without a physician's referral? YES NO

Did you know that you have a choice as to where you receive physical/occupational therapy services, including Workman's Compensation, even if your physician sends a specific referral slip to a given facility? An exception is if your <u>HMO</u> insurance limits you to one provider. YES NO