

WOODINVILLE PHYSICAL & HAND THERAPY
PATIENT INFORMATION

Date _____

Patient Name _____ () Male () Female
(First) (Last) (MI)

How would you like to be addressed? () First Name () Surname () Nickname _____

HomeAddress _____

(Number and Street) (Apt. #) (City, State, Zip)
Home Phone () _____ - _____ Work Phone () _____ - _____ Cell Phone () _____ - _____

Please circle preferred contact number above Email Address _____

Date of Birth ___/___/___ SS# ___-___-___ Patient Employer _____

___ Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Minor

Spouse Name _____ SS# ___-___-___ Spouse Employer _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE SECTION BELOW!

Mother's Name _____ SS# ___-___-___
(First) (Last) (MI)

Employer _____ Phone () _____ - _____

Father's Name _____ SS# ___-___-___
(First) (Last) (MI)

Employer _____ Phone () _____ - _____

PAYMENT/INSURANCE

Health Insurance - Primary _____ Subscriber _____ Date of Birth ___/___/___

Health Insurance - Secondary _____ Subscriber _____ Date of Birth ___/___/___

***Is your injury related to one of the following? ___ MVA ___ On the Job Claim # _____

Insurance _____ Date of Injury ___/___/___
(Name, Street #, City, State & Zip)

Referring Physician _____ Family Physician _____

EMERGENCY INFORMATION

(In case of emergency, we would appreciate the name of the contact, NOT living with you at the same address)

#1- Name _____ Phone () _____ - _____
(First) (Last)

Please read the following statement carefully before signing.

I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize the clinic to receive all benefits to which my dependents or I are entitled to under my health insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. The undersigned agrees that whether he/she signs as an agent that he/she is obligated to pay for the account. Should the account exceed an amount that the undersigned is unable to pay in full, agreed upon payments by the undersigned and the clinic can be established with a 1% interest per month (RCW 19.52) on the unpaid balance. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of interest on the unpaid balance at 1% per month form the date of service, collection fees, reasonable attorney fees and court costs. I have also been informed of the \$35 fee (per RCW 62A.3-515 & 520) on checks returned NSF.

Signed _____ Date ___/___/___

Signed _____ Date ___/___/___

Signed _____ Date ___/___/___