

PATRICK PHYSICAL THERAPY, INC.

10542 Pico Blvd.
W. Los Angeles, CA 90064
Phone: (310) 838-3331
Fax: (310) 838-9992

14301 Ventura Blvd.
Sherman Oaks, CA 91423
Phone: (818) 995-0918
Fax: (818) 385-0021

11845 W. Olympic Blvd. #100
W. Los Angeles, CA 90064
Phone: (310) 694-5371
Fax: (310) 477-7703

PATIENT INFORMATION FORM

DATE _____

NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
SEX: MALE _____ FEMALE _____
CREDIT CARD _____ EXP. DATE: _____
MD UPIN/NPI # _____

SOCIAL SECURITY NUMBER _____
MEDICARE NUMBER _____
DATE OF BIRTH _____
PHONE _____
CELL PHONE _____
MD _____
DIAGNOSIS _____

EMPLOYMENT STATUS

EMPLOYER _____
ADDRESS _____
CITY _____

STATE _____ ZIP _____
PHONE _____

INSURANCE INFORMATION

COMPANY _____
ADDRESS _____
CITY _____
NAME OF INSURED _____

STATE _____ ZIP _____
PHONE _____
GROUP/POLICY # _____

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to:

PATRICK PHYSICAL THERAPY, INC.
14301 VENTURA BLVD., SHERMAN OAKS, CA 91423

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you to make check out to me and mail it to the above address. I agree that any co-payments or unpaid balances can be charge on my credit card during my treatment or after I have been discharged.

For the professional or medical expense benefits allowable, and otherwise charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above any insurance payment. I also agree that if above stated company needs to acquire legal services to recover my indebtedness, I agree to pay for any and all legal fees required to collect payment. A photocopy of this assignment shall be considered as affective and valid as the original. I also authorize the release of any and all medical records, as well as other information, pertinent to my case to any insurance company, adjuster or attorney involved in the case.

I authorize any or all previous medical records be forwarded or copied to Rhett Patrick Physical Therapy so they may perform prescribed services. I also authorize Rhett Patrick Physical Therapy to initiate any complaints to the Insurance Commissioner for any reason on my behalf.

Signature Of Policy Holder

Witness

Date

_____ Signature Of Claimant, If other than policy holder.