

BACK2NORMAL

PHYSICAL THERAPY

Name (Last, first, m)		SSN	Date of Birth (DOB)	Sex <input type="checkbox"/> F <input type="checkbox"/> M
Address				
Driver's License Number	Home Phone	Cell Phone	Marital Status	
E-mail (Primary)		E-mail (Secondary)		
Employer's Name		Employer's Telephone Number		
Employer's Address				

EMERGENCY CONTACT

Name	Telephone	Relationship
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REFERRAL PHYSICIAN (Physician that referred you to us or primary care doctor)

Name	Telephone	Specialty
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PATIENT ADVOCATES (Parties Authorized to Receive Patient Health Information)

Name	Telephone	Relationship
Name	Telephone	Relationship

FINANCIAL GUARANTOR INFORMATION

Self (Skip this Block)

Person Responsible for Account	SSN	Date of Birth (DOB)	Occupation
Address (If different from patient)			
Relationship to Patient	Home Phone	Cell Phone	

I understand and agree that (regardless of my insurance status) I am responsible for all charges at the time of service.

I hereby authorize Back to Normal Physical Therapy (BTN) the use of this signature on all insurance submissions and certify that the information hereby provided is true and correct to the best of my knowledge.

In signing this form I agree that copies of this assignment are considered valid and may be used in place of the originals.

Signature of Patient/Responsible Party

DATE