101 physical therapy, inc.

5704 Main Street, Ooltewah, TN 37363 ◆ phone 423.238.1301 ◆ fax 423.238.1302 ◆ www.101pt.com

Patient Information

Name:_____ D.O.B.:_____ / _____ / _____ SSN: _____ --- _____ --- _____

Address:_____ City: _____ State:_____ Zip:_____-_____

Phone # (H): (_____) _____-_____ Phone # (C): (_____) _____-_____ Email: _____

Employer _____ Address_____

Primary Insurance Info:

(Please leave this area blank.
Your insurance card will be copied during your office visit.)

Secondary Insurance (if applicable):

(Please leave this area blank.
Your insurance card will be copied during your office visit.)

Are you *currently* under anyone else's care for this problem (e.g., chiropractor, LMT, etc.)? Y ☐ N ☐

If Yes, whom? _____

When were you last seen by your physician? _____

Have you had any special studies done for this problem? (e.g., X-Rays, CT Scan, MRI, etc.)

If Yes, do you have copies of the study results? ☐ Y ☐ N

Signature: I authorize release of medical information necessary to process my insurance claims and assign payment (if I have not already paid) to 101 Physical Therapy, Inc. or its agent for services rendered. ADDITIONALLY, I understand I am responsible for these charges regardless of insurance coverage. If this account is placed with an attorney or agency for collection, I hereby agree to pay any reasonable and necessary collection fee. Furthermore, I understand that my medical records may not be released until my account is paid in full.

*Date*_____ *Signature*_____