Six Points Physical Therapy
701 Park Avenue-Corpus Christi, Texas 78401
Office: 361-879-0006 Fax: 361-879-0702

Patient Information

Date: _____ Home: _____ Cell: _____
Permission to leave message? Yes_____ No_____

Name: _____ SS# _____

Responsible Party: (if minor) _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Sex: _____M _____F Age: _____ D.O.B. _____ Marital Status: S M W D

Patient Employed By: _____ Occupation: _____

Do you have Medical Insurance? No_____ YES _____ **If Yes, please present your card to the front office**

In case of an Emergency Notify: _____ Phone: _____

List of person(s) who we may disclose medical information to:
Name: _____ Relation: _____

Name: _____ Relation: _____

Next Appointment with referring doctor: _____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to Six Points Physical Therapy all insurance benefits, if any, otherwise payable to my services rendered. I hereby authorize the therapist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date: _____

Six Points Physical Therapy will know how much the patient's insurance will cover for each visit upon receiving the first Explanation of Benefit (EOB). This may take 2-4 weeks. Rest assure that your benefits have been verified prior to your first visit which informs us of any out of pocket expense (co-payments and/ or deductibles). **For private pay patients:** Six Points Physical therapy will charge a fee of $80.00 for the Initial Evaluation and $60.00 for regular sessions. **Patient's with health insurance are responsible to inform the front office of any insurance changes that can affect payment for services rendered. Otherwise, the patient is solely responsible for the bill of the services rendered at Six Points Physical Therapy**. I understand that I am entitled to receive a copy of this document.

Patient Name: (print) _____

Patient Signature: _____ Date: _____

CONSENT TO RELEASE MEDICAL RECORDS

I _____, give permission for Six Points Physical Therapy to release my Medical Records to my referring physician and my corresponding medical insurance(s) at the time of service.

Patient Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT/ REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how medical information will be used and disclosed.

Patient Signature: _____ Date: _____