LAYTON PHYSICAL THERAPY CO., INC.
REHABILITATION SERVICES

LAST NAME _____ FIRST _____ MI _____

MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ EMAIL _____

SEX: M F AGE _____ DOB _____ SS# _____

PLACE OF EMPLOYMENT _____ OCCUPATION _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____

EMERGENCY CONTACT _____ PHONE _____ RELATIONSHIP _____

PRIMARY HEALTH INSURANCE COVERAGE

INS. COMPANY _____

EFFECTIVE DATE _____

POLICY HOLDER _____

POLICY HOLDER SS# _____

POLICY HOLDER DATE OF BIRTH _____

EMPLOYER _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COVERAGE

INS. COMPANY _____

EFFECTIVE DATE _____

POLICY HOLDER _____

POLICY HOLDER SS# _____

POLICY HOLDER DATE OF BIRTH _____

EMPLOYER _____

RELATIONSHIP TO PATIENT _____

MOTOR VEHICLE ACCIDENT (MVA)

DATE OF ACCIDENT _____

BILL TO: ATTY___ AUTO INS___HEALTH INS___ SELF___

NAME OF INS. CO./ATTY _____

ADDRESS _____

_____ PHONE _____

Auto Ins. Only:

INSURED'S NAME _____

WORKERS' COMPENSATION CLAIM

EMPLOYER _____

DATE OF INJURY _____

INJURY SITE _____

TELEPHONE _____

CONTACT NAME _____

HAVE YOU EVER BEEN REFERRED TO VOCATIONAL REHAB? Y N
(If yes, you would have signed BWC paperwork indicating this)

HAVE YOU PREVIOUSLY RECEIVED PHYS. THERAPY SERVICES FOR THIS OR ANY OTHER CONDITION? ____YES ____NO

WHERE? _____ **HOW MANY?** _____

I acknowledge that I have provided Layton Physical Therapy Co., Inc. with all insurance and/or workers compensation information necessary to insure proper billing for services rendered. I hereby authorize the release of necessary information to authorized agencies, employees, and/or insurance companies. I authorize payment to be made directly to Layton Physical Therapy. Although Layton Physical Therapy may bill my insurance carrier, I understand that payment is not gauranteed and that I will be held responsible for any unpaid amounts, or non-covered services, as well my co-payments, co-insurance, deductibles and/or attorney fees should collection proceedings be necessary. I give Layton Physical Therapy permission to treat me per physicians orders.

_____ _____

SIGNED PATIENT (PARENT IF MINOR-GUARDIAN-LEGAL REPR.) **DATE**