DESERT EDGE
PHYSICAL THERAPY
Move better. Live better.

Patient & Billing Information

Patient Information

Name: Last_____ First_____ Preferred _____ Middle Initial_____

Gender ☐ M ☐ F Age _____ DOB ___ /___ /_____ SSN _____ Student: ☐ Yes: FT / PT ☐ No

Marital Status: ☐ Married ☐ Single ☐ Other Race _____ Language Preference _____

Address _____ City, State, Zip _____

Phone Numbers: Home _____ Work _____ Mobile _____

Email _____ Preferred Phone ☐ Home ☐ Work ☐ Cell

Would you like appointment reminders? ☐Yes ☐No How would you like to receive them? ☐Voice ☐Email

How did you hear about us? ☐ Doctor ☐ Friend/Family ☐ Social Media/Online ☐ Other _____

Please give us the name of the person who referred you so we can thank them! _____

Referring Physician _____ Primary Care Physician _____

Billing Information

Responsible Party Name: Last_____ First_____ Middle Initial_____

Phone Numbers: Home _____ Work _____ Mobile _____

SSN_____ DOB_____ Relationship to Patient_____

Address _____ City, State, Zip _____

Employer_____

Employer Address _____ City, State, Zip _____

Is this a Worker's Comp case? ☐ YES ☐ NO

Case # _____ Case Manager Name _____ Phone _____

Insurance Information

Primary Insurance _____

Phone _____

Address _____

Subscriber Name _____

Subscriber Date of Birth _____

Relationship to Patient _____

Insured Policy ID # _____

Group Number _____

Effective Dates _____

Secondary Insurance _____

Phone _____

Address _____

Subscriber Name _____

Subscriber Date of Birth _____

Relationship to Patient _____

Insured Policy ID # _____

Group Number _____

Effective Dates _____

Emergency Contact

Name: Last_____ First_____ Relationship to Patient _____

Address_____ City, State, Zip _____

Phone Numbers: Home _____ Work _____ Mobile _____

Release of Information

I authorize Desert Edge Physical Therapy to provide my confidential health information to the following individuals:

Name: Last_____ First_____ Relationship to Patient _____

Name: Last_____ First_____ Relationship to Patient _____

Authorizations

☐ I hereby certify that the above information is complete and accurate according to the best of my knowledge and ability.

☐ I understand it is my responsibility to understand my health insurance benefits, verify necessary referrals/authorizations are on file, and pay subsequent out of pocket expenses. I request and authorize my health insurance carrier to pay Desert Edge Physical Therapy for all charges related to services provided to me. I understand that I am entirely financially responsible to Desert Edge Physical Therapy for all services rendered and agree to pay in full any amounts not paid by an insurance company or other third party payers in addition to all co-payments, deductibles, or co-insurance. Should my account go to collections, I agree to pay all attorneys fees, court costs, filing fees, and all other charges that may be assessed. I further agree to pay interest in the amount of 1.5% per month on any balance over 90 days.

☐ I understand that not showing for scheduled appointments will delay my plan of care, and that if I cannot attend one of my scheduled appointments, I must give a minimum of 24-hour notice when canceling. Failure to do so will result in a $25 fee.

☐ I understand that the information provided above may be used and shared for the purposes of treatment, billing for services rendered, and conducting of administrative operations of Desert Edge Physical Therapy per their **Notice of Privacy Practices** which I have had an opportunity to read, review, and receive.

☐ I give my consent to proceed with a therapy evaluation and corresponding treatment. I also give my consent that services may be observed and/or provided by a PT or PTA student under the supervision and instruction of a licensed physical therapist. Due to the nature of physical therapy and the physical exertion required to perform activities with increasing degrees of difficulty, I understand that there may be possible complications associated with my care such as an increase in my current level of pain, an aggravation of my existing injury, or very rarely, the development of a new injury. My signature below acts as a waiver of liability for treatment received at Desert Edge Physical Therapy excepting acts of negligence.

Patient/Guardian Signature: _____ Date: _____

Patient Name (Print): _____