New Patient Information:

Beyond Limits Physical Therapy
Helping you live, work and play better

Patient Name: _____ Phone: _____ Cell: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Employer: _____

SS#: _____ Date of Birth: _____ Age: _____ Sex: M / F

Emergency Contact: _____ Emergency Phone: _____

Email: _____ May we send pertinent information by email? Y / N

*Appointment reminders (please choose one): ☐Text_____ ☐Phone Call_____ ☐Email
(Indicate preferred phone #) (Indicate preferred phone #)

Responsible Party (If different than patient):

Name: _____ Relation:_____ Phone: _____ Cell: _____

Address: _____ Work Phone: _____

City/State/Zip: _____ Employer: _____

SS#: _____ Date of Birth: _____ Sex: M / F

Insurance Information:

Primary: _____ **Secondary:** _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Relation: _____ Date of Birth: _____ Relation: _____ Date of Birth: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Policy/Claim #: _____ Policy/Claim #: _____

Claim Adjuster's Name & Phone (auto or workers comp):_____

Attorney's Name & Phone: _____

Other Information:

Briefly describe your condition: _____ Date of onset/accident: _____

Is condition related to a motor vehicle accident? Y / N *If YES, which state did the motor vehicle accident occur? _____

Is condition an employment related injury? Y / N

Who may we thank for referring you to our office? ☐ Physician ☐ Insurance ☐ Phone book ☐Internet
☐ Former patient_____ ☐ Other_____

Initial the following statements and sign below:

Initial I authorize Beyond Limits Physical Therapy (BLPT) to use and disclose health and medical information for the purposes of treatment, payment and healthcare operations. I consent to physical therapy services prescribed by my physician and/or those services deemed to be for my benefit.

Initial I have received this practice's Notice of Privacy Practices written in plain language.

Initial Under all circumstances I assume final responsibility for my account. I authorize payment of medical benefits by my insurance company or attorney to BLPT for services rendered. I understand BLPT may charge interest on any account balance older than 60 days in the amount of 18% annually, with a minimum charge of $1.00 per month. If my account is more than 90 days delinquent, it may be turned over to a collection agency and reported to the credit bureau. I agree to pay all collection costs including an additional 40% collection fee and all attorney and legal fees if referred to an agency. A $20 fee will be charged on all returned checks. BLPT reserves the right to charge $25 for all visits missed or cancelled without 24 hour advance notice.

Initial I understand that BLPT may verify my insurance benefits as a courtesy to me, but it is also my own responsibility to know and verify my own benefits with my insurance company. BLPT is not responsible for misquoted benefits by my insurance.

Initial I acknowledge that in addition to paper statements, BLPT may send me billing reminders via text message. I agree to update BLPT if my address or mobile number changes. My mobile number is _____

Signature: _____ Relation: _____ Date: _____
(Parent or guardian signature required if patient is a minor)