Alves & Martinez
Physical Therapy & Athletic Performance

PATIENT INFORMATION

☐ **CASH PAY**
☐ **Returning Patient**

Name: _____ Birth date: _____ Sex: ☐ Male ☐ Female

SSN: _____ - _____ -_____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other

Physical Address: _____ City _____State _____ Zip _____

Mailing Address (if different from above):
_____ City_____ State_____ Zip_____

**** Please provide your contact phone numbers and check your preference:**

☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Other #: _____

Email Address: _____

How would you like to receive appointment reminders? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Doctor: _____ Referral Date: _____ OR ☐ Self Referral

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☐ **WORKER'S COMP** Injury at Work? ☐ Yes ☐ No Motor Vehicle Accident? ☐ Yes ☐ No

Insurance Name: _____

Adjuster: _____ Phone: _____ Fax: _____

Address: _____ City _____State _____Zip _____

Claim# _____ Date of Injury _____ Surgery: _____

Employment Status before injury: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not-working ☐ Other _____

Employer Name: _____ Employer phone: _____

Address: _____ City _____State _____ Zip _____

Attorney Information (If have one):

Attorney Name: _____ Phone: _____ Fax: _____

Address: _____ City _____ State _____ Zip _____

☐ **MOTOR VEHICLE ACCIDENT** ☐ **Med Pay** Amount: $_____ ☐ **Med Pay Access** Amount: $_____

Insurance Name: _____ Policy #: _____

Adjuster: _____ Phone: _____ Fax: _____

Address: _____ City _____State _____Zip _____

Claim# _____ Date of Accident: _____

TURN OVER

PATIENT INFORMATION (Continued)

AUTHORIATION and ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby agree and give my consent for Alves & Martinez Physical Therapy and Athletic Performance to furnish medical care and treatment considered necessary and proper in diagnosing or treating my physical condition.

Initial_____

I have read and fully understand *Alves & Martinez Physical Therapy's Notice of Information Practices.* I understand that Alves & Martinez Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Alves & Martinez Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Initial_____

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Alves & Martinez Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initial_____

APPOINTMENT POLICY

PLEASE BE TIMELY FOR APPOINTMENTS. If you arrive more than 15 minutes late for your scheduled appointment, you may have to be rescheduled. This is for the benefit of you and other patients being treated.

WHEN ABLE, PLEASE SCHEDULE YOUR APPOINTMENT ONE WEEK IN ADVANCE TO ENSURE THE TIMES THAT YOU NEED. Appointment times given one week do not automatically follow through to the subsequent weeks.

The patient and the therapist will discuss the importance of the frequency and duration at your first appointment.

Thank you for your cooperation!

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ **Date:** _____

RETURNING PATIENT ONLY

All information given before remains the same. Alves & Martinez Physical Therapy and Athletic Performance have been notified of any changes.

Patient or Guardian: _____ **Date:** _____