AGM Physical Therapy

PATIENT INFORMATION

Patient Name	Birthdate	Preferred phone number #1 Home Cell Work
Address	Apt./Suite No.	Preferred phone number #2 Home Cell Work
City, State, Zip Code		Email

Parent or Guardian Name if applicable:	Marital Status S M D W Leg Sep	Gender M F
Occupation	Patient's Employer & Work Address	Employer's Phone

May we, or our authorized agents, leave a message or contact you on the above phone numbers or via email regarding your care, scheduling, follow-up, and billing?

Phone #1 ☐ YES ☐NO Phone #2 ☐ YES ☐NO Email ☐ YES ☐NO

If no, which number may we, or our authorized agents, utilize regarding payment? (_______)_______-______________

AGM may discuss my account or care with the following individual(s) ___________________________________.

Emergency Contact's Name	Contact's Phone Number:	Relationship to Patient	
Is this a work related injury? ☐ YES ☐NO If YES date of inury:	BWC Claim #	MCO Name:	MCO Phone number:
Is this injury related to a Motor Vehicle Accident? ☐ YES ☐ NO IF YES PLEASE SEE RECEPTIONIST.	Date of injury	Insurance Company:	
Name of Attorney	Attorney Phone number:	Claim #:	

INSURANCE INFORMATION

Primary Insurance Name	Policy Number:	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address	Policyholder's Phone	
Secondary Insurance Name	Policy Number:	Policyholder's Birthdate	Relationship to Patient
PolicyHolder's Name (if other than patient)	PolicyHolder's Home Address	Policyholder's Phone	

GUARANTOR INFORMATION - (List person RESPONSIBLE FOR THE BILL IF OTHER THAN PATIENT)

Last Name	First Name	Middle Initial	Relationship of Guarantor to Patient
Mailing address:	Apt./Suite No.	Contact phone	
City, State, Zip Code		Email address	

REFERRAL INFORMATION

Were you referred by a physician? ☐ YES ☐NO	If yes, name of physician

How did you hear about AGM Physical Therapy? ☐ Insurance company ☐ Employer ☐ Attorney ☐ Website ☐ Internet ☐ Drive-by

☐ Friend please list name ___________________________________

Other Pertinent Information

Have you had any type of therapy this year? Yes No If so, how many visits? ___________

Are you receiving Home Health Services of any kind at this time? **Yes** No ***If yes, please inform receptionist at***

I certify that the information provided is correct to the best of my knkowledge. I will not hold AGM Physical Therapy, it's health providers, or it's employees responsible for any errors or omissions that I may have made in completing the information on this form. I give my consent for treatment, authorize the release of necessary information to insurance carriers & appropriate personnel, & request that my insurance carriers pay AGM directly.

I hereby give my consent for AGM Physical Therapy to use and disclose protected health information about me to carry out treatment, payment and health care operations. I am consenting to allow AGM Physical Therapy and it's authorized agents to use and disclose my protected health information to carry out treatment, payment and health care operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, AGM Physical Therapy may decline to provide treatment to me.

Patient/Guardian Signature____ Date _________________________