Patient Contact and Billing Information

Patient name _____ DOB _____ Age _____
Address _____
Street **City** **State** **Zip**
Home phone _____ SSN _____ Marital status _____
Picture ID number (ID or License Number) _____
Provide a reason for not having a number _____
Employer _____ Work phone _____
Referring medical provider _____
Emergency contact _____
Relation Phone

For patients under 18

Guardian's name _____ Relationship to patient _____
Address (if different from above) _____
Phone (if different from above) _____
In case of emergency, notify _____ Relationship _____

Billing Information *(If this information is incomplete, we will send the bills to the patient.)*

Insurance carrier _____ Policy holder _____
Address _____ Phone _____
Policy # _____ Group # _____
Secondary insurance carrier _____ Policy holder _____
Address _____ Phone _____
Policy # _____ Group # _____

By signing, I authorize the release of my medical information necessary to process this claim. By signing, I also authorize payment of medical benefits to Alpine Physical Therapy. Your account is between Alpine Physical Therapy and you as our patient. The responsibility of payment remains with you, regardless of insurance coverage. We do not accept responsibility for collecting your insurance claim or for negotiation a settlement on your claim. You are responsible for payment of your account within the limits of our credit policy as final payer. Accounts not paid by insurance within 90 days become the responsibility of the patient/guardian.

Signature _____ Date _____
(Patient, parent, or legal guardian)