PATIENT INFORMATION

First Name Middle Last	Birth date / /	Marital Status M W S D	Sex M F
Street Address City State Zip			
Home Phone	Work Phone	Date of Accident, Injury, or First Symptom	Social Security #
Employer	Employer Address		
Next of Kin/Emergency Contact Name	Relationship	Phone #	
How did you hear about AIM Physical Therapy?			

INDIVIDUAL RESPONSIBLE FOR PAYMENT (complete if not the same as above or under the age of 18 years old)

First Name Middle Last	Relationship		
Street Address City State Zip			
Home Phone	Work Phone	Employer	Social Security #
Employer Address			

PRIMARY INSURANCE COMPANY (not including workers comp or motor vehicle)

Name	Policy ID No.	Group #
Street Address City State Zip		
Name of Policy Holder	Policy Holder's Date of Birth	Patient's Relationship to Policy Holder
Policy Holder's Address		Policy Holder's Phone #

ASSIGNMENT OF BENEFITS

I understand that I am responsible for full payment after insurance consideration. I authorize payment of benefits from my insurance be paid directly to AIM Physical Therapy Clinic. I also authorize AIM Physical Therapy Clinic to release to my insurance company any and all information necessary for the processing of insurance claims.

I hereby authorize the physical therapist in charge of the above named patient to administer treatment necessary or advisable.

I hereby authorize payment of Medicare benefits be made to AIM Physical Therapy Clinic for any services furnished by the listed provider. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

Signature______________________________ Date______________________