Chattanooga Physical Therapy

1201 Market Street, Suite A
Chattanooga, TN 37402

Patient Information:

Last Name:_____ First Name_____ MI:_____

Male___ Female___ Age___ Date of Birth: _____ Social Security #_____

Best Phone # to reach you:_____ Secondary Phone #:_____

Email Address:_____

_____
Street Address (please include mailing address if different) City State Zip

_____ _____ _____
Emergency Contact Name Relationship to you Emergency Contact #

Referring Physician: _____ Physician's Phone #:_____

Insurance Information: **We will need a copy of your current insurance card.**

How did you hear about Chattanooga Physical Therapy?

- ☐ My Doctor
- ☐ Family
- ☐ Friend
- ☐ I am a repeat patient
- ☐ Advertisement / Website
- ☐ Other_____

Name of referral? _____

- I understand that I am financially responsible for all charges whether or not paid by insurance. I understand and agree that health and accident insurance policies are an arrangement between me and the insurance company. Further more, I understand that this office will prepare any necessary reports and forms to assist in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. Return Check Charge will be $30.
- I will come appropriately dressed for therapy i.e. back and leg conditions wear sweats or shorts.
- Discharge due to absence will be reported to my physician and insurance adjuster and may result in discontinuation of worker's compensation benefits if I am being seen under worker's compensation coverage.

_____ _____ _____
Patient Signature Parent or Guardian Signature (If patient is under age 18) Date