

**PATIENT INFORMATION**

Last Name _____		First Name _____	
Street Address _____			
City _____		State _____	Zip _____
Email Address _____		Cell Phone ( ) _____	
Home Telephone ( ) _____		Work Telephone ( ) _____	
Date of Birth _____		Social Security # _____	
Physician _____		Ailment _____	
Sex ( )M ( )F	Emergency Contact _____		Phone ( ) _____

**Responsible Party Information**

Relationship to Patient: ( )Self ( )Spouse ( )Parent ( )Other			
Last Name _____		First Name _____	
Street Address _____			
City _____		State _____	Zip _____
Email Address _____			
Home Telephone ( ) _____		Work Telephone ( ) _____	
Date of Birth _____		Social Security # _____	

**Employer Information**

Employer Name _____			
Work Telephone ( ) _____		Job Title _____	
Street Address _____			
City _____		State _____	Zip _____

I authorize Focus Physical Therapy to release any medical or other information acquired during my Examination and/or treatment to any insurance company, employer, hospital or physician. I also request payment of government benefit to myself or to the party who accepts assignment. I assign/authorize payment of medical benefits to Focus Physical Therapy for all services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Focus does not accept responsibility for collecting on or negotiating the settlement of any legally deputed claims.

I authorize Focus Physical Therapy to render physical therapy services as prescribed by the attending physician.

\_\_\_\_\_  
Patient/Responsible Party

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date