Body Elite Physical Therapy, Inc.

3052 Valley Avenue, Suite 101
Winchester, VA 22601

Patient Information

SSN:_____Primary Care Physician_____Referring Physician_____

Patient's Last Name:_____First_____Middle Initial_____

Address:_____City_____State_____Zip_____

Telephone Home:_____Work:_____Cell:_____Date of Birth:_____

Email:_____ I prefer to be contacted by_____

Marital Status (please circle) Single Married Divorced Separated Widowed

Chose clinic because (please check one) • Dr. • Insurance Plan • Internet • Family
• Friend • Close to home/work • Yellow Pages • Other _____

In Case of Emergency

Contact:_____Relationship to Patient_____Phone_____

Insurance Information

Please Indicate Primary Insurance and ID #_____

Policy Holder's Last Name:_____First_____Middle Initial_____

Address (if different):_____City_____State_____Zip_____

Date of Birth_____ Secondary Insurance if applicable _____

Patient's Relationship to Policy Holder: • Self • Spouse • Child • Other Policy Holder DOB:_____

Workers Compensation Information

Name and Address of Employer:_____
_____

The above information is true to the best of my knowledge. I authorize Body Elite Physical Therapy, Inc. to provide treatment to myself and / or above named patient. I also authorize the release of any information required to process my claims to my insurance carrier(s) by Body Elite Physical Therapy, Inc. I also authorize my insurance benefits be paid directly to Body Elite Physical Therapy, Inc. I understand that I am financially responsible for any balance after insurance has made payment.

Patient / Guardian Signature **Date**

_____ _____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations.

Patient / Guardian Signature **Date**

_____ _____

Office Use Only

Coverage_____ Copay or Co-Insurance_____
Deductible Amount_____How much has been met this year_____ When does it start_____
Limit of Visits_____Used this year_____
Pre-authorization _____