SALMON CREEK
Physical Therapy
CLINIC, P.S.

Today's Date .....

Account Number .....

Referring Physician: Telephone#

Name:
Last First Middle

Address: Zip Code:

Telephone: Birth Date:

Employer: SSN#

Employer's Address: Telephone:

Spouses Name:

Spouses Employer: Telephone:

Name of person not living with you to contact in case of emergency: Their Telephone:

INSURANCE INFORMATION:

Primary Insurance: Group# ID/SSN

Telephone: Name of Insured:

Address:

Secondary Insurance: Group# ID/SSN

Telephone: Name of Insured:

Address:

COMPLETE ONLY IF USING MEDICAL COUPONS Are you eligible for assistance through the Dept of Social & Health Services? ☐ Yes ☐ No

If yes, have you had any physical therapy within this calender year? ☐ Yes ☐ No

COMPLETE ONLY IF ON THE JOB INJURY: State in which Injury Occurred:

Employer at time of Injury: Date of Injury:

Insurance Company: Telephone:

Address:

Claim Adjuster: Claim#

Complete "ONLY" if auto accident: Check to Bill "MY" Insurance ☐ or "OTHER" responsible party ☐ State Injured In:

Insurance Company: Telephone:

Address:

Claim Adjuster: Claim# Date of Injury:

Name of Insured: Relationship to Insured:

Please Note: Even though, you the patient, may not be at fault with regard to this motor vehicle accident, it is best to bill your insurance company. They in turn will recover funds from the responsible party. Salmon Creek Physical Therapy will bill the insurance company twice monthly.

Would you like to receive a monthly statement?_____

If an attorney is handling your claim, either motor vehicle or on the job injury, please give the following information:

Attorney's Name: Address: Telephone:

Welcome to our office. Our staff is here to help you obtain the care you need in a pleasant and efficient manner. In the interest of good medical practice, it is important to establish a credit policy to avoid misunderstandings. WE WILL BILL ALL INSURANCE COMPANIES DIRECTLY if we have pertinent billing information. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE for services rendered.
I authorized my insurance carrier to pay benefits directly to SALMON CREEK PHYSICAL THERAPY. If balance becomes delinquent, I agree to pay all collection costs. Accounts over 60 days may be subject to a monthly finance charge of 12% of the unpaid balance, UNLESS financial arrangements have been made prior.
I authorize release of medical information to my insurance company, and assign all benefits to SALMON CREEK PHYSICAL THERAPY.

Signature of Patient or person assuming financial responsibility_____ Date:_____