ADVANCED ORTHOPEDIC REHABILITATION

2031 W. Alameda Ave., Ste. 300
Burbank, CA 91506
Tel: 818-558-6843 * Fax 818-558-1487
aorphysicaltherapy.com

PATIENT INFORMATION FORM

Referring Physician: ____________

Name: ____________ Age: ____________ Date of Birth: ____________

Home Address: ____________
Street **City & State** **Zip Code**

Home #: ____________ Mobile #: ____________ Bus. # ____________

Email Address: ____________ Employer: ____________

Business Address: ____________
Street **City & State** **Zip Code**

Driver's License # & State ____________ Social Security #: ____________

Emergency Contact: ____________ Phone #: ____________

How did you hear of us? *MD Referral* *Attorney* *Friend/Family:* *Name:* ____________

Internet: *Yahoo* *Google* *Other website* *Insurance Directory* *Brochure/print ad*

BILLING AND INSURANCE INFORMATION

Please Circle One: *Worker's Comp* *Personal Injury* *Insurance* *Cash*

Name of Insurance Carrier: ____________ Date Of Injury: ____________

Address: ____________
Street **City & State** **Zip Code**

Adjuster's Name: ____________ Phone Number: ____________

Subscriber #: ____________ Group #: ____________ WCAB Case # ____________

Insured Party: *Self* *Spouse* *Father* *Mother* *Other(name and relationship)* ____________

Address(of other): ____________ Phone Number: ____________

Do you have an attorney for this injury (please circle one)? Yes No Attorney Name: ____________

Attorney Address: ____________ Phone Number: ____________

AUTHORIZATION TO PAY PHYSICAL THERAPIST AND FINANCIAL AGREEMENT

I hereby authorize the physical therapist in charge of my case to furnish my insurance company with information concerning my medical or physical therapy treatment.

I hereby authorize and instruct my insurance company to pay by check made out and mailed directly to: ADVANCED ORTHOPEDIC REHABILITATION, 2031 W. Alameda Ave., Burbank, CA 91506 the medical and physical therapy benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not extend my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment. If legal action becomes necessary to enforce payment, I agree to pay a reasonable attorney fee.

____________ ____________
Signature of Insured Date