MIDWEST™
PHYSICAL
THERAPY
2431 CORAL COURT #2
CORALVILLE, IOWA
5 2 2 4 1

EMERGENCY CONTACT Name: Phone:

Referring doctor: Shall we send him/her a report? Yes No

Patient Name: E-Mail Address:

Birth Date: SSN:

Address: City/State/Zip

Phone: Home: ( ) Cell: ( ) Work: ( )

Occupation/Employer/School:

Employer Address:

Are your symptoms caused by: Work? Y / N | Automobile Accident? Y / N | Fall? Y / N

If answering Yes to any of the above factors, provide: Date of Incident _____ State in which incident occurred ____

If insured by spouse or parent please complete the following:

Spouse/parent/significant other:

Address: Spouse/parent Birth Date:

Spouse or parent Employer:

Insurance/Billing Information (Also make a copy of insurance card.)

- **Please note:** Midwest Physical Therapy will make every effort to submit your insurance claims accurately. However, the submission of claims is dependent upon the accuracy of information provided. If, after submitting your insurance claims, your coverage is denied, you are responsible for the full billed amount for the dates of service you received care from Midwest Physical Therapy.

  Signature: _____ Date: _____

- If you are receiving physical therapy due to injury at work, please complete the following:

  Employer Name: _____ Contact Person: _____

  Employer Address: _____ Employer Phone: _____

- If you are receiving physical therapy due to a car accident, please complete the following:

  Your car insurance information: _____

  Agent Name and phone number: _____

  Responsible party's car insurance information: _____

  Claim Number: _____ Attorney: _____

I hereby authorize **Midwest Physical Therapy, P.C.** to furnish the insurance company, including Medicare, with all information requested relating to my illness or injury. I authorize payment to be made to **Midwest Physical Therapy, P.C.** by commercial or government insurance companies for physical therapy treatment and supply expenses rendered from time to time, but not to exceed my indebtedness.

I understand that I am financially responsible to **Midwest Physical Therapy, P.C.** for all expenses incurred. I further understand that if there has been no payment toward my account in excess of 60 days, I will be charged an administrative fee of $5.

Signature: Date: