PURSUIT PHYSICAL THERAPY

Appt. Date

PATIENT INFORMATION

Last Name	First	MI	Date of Birth	Social Security Number: - -	Male ☐ Female ☐
Home Address	City	State	Zip Code	Home Phone	Cell Phone
Marital Status ☐ Single ☐ Married ☐ Other	Have you been treated at Pursuit Physical Therapy clinic before? If yes, when?				
Employment Status ☐ Employed ☐ Student ☐ N/A	Employer Name/School Name			Title/Position	
Work Address	City	State	Zip Code	Work Phone	
E-Mail Address	Preferred Appointment Reminder ☐ Call ☐ Email ☐ Text				

REFERRING PHYSICIAN INFORMATION

Last Name	First	MI	Address	Telephone

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION

Last Name	First	MI	
Address	City	State	Postal Code
Home Phone	Work Phone		
Relationship ☐ Spouse ☐ Parent ☐ Guardian	Parent or Guardian E-Mail Address		

REASON FOR TODAY'S VISIT

Is this injury/condition related to …

Your Job ☐ Yes ☐ No	An Auto Accident ☐ Yes ☐ No	A Home Accident ☐ Yes ☐ No	Other Accident ☐ Yes ☐ No
Please indicate the date of your accident/injury:	Please indicate the date of your illness (1st symptom):		
Please provide name of insurance adjuster or contact:	Telephone		
Please describe your injury/accident/illness:			

RESPONSIBLE PARTY STATEMENT

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

Responsible Party Signature	Date

PRIMARY INSURANCE COMPANY INFORMATION

Primary Insurance Company Name		Identification Number		Group Number
Address	City	State	Zip Code	Telephone
Policyholder *(if other than patient)*		☐ Male ☐ Female		Date of Birth
Social Security Number *(of policyholder)*	Telephone *(of policyholder)*			Relationship to Patient
Employer *(of policyholder)*				

SECONDARY INSURANCE COMPANY INFORMATION

Secondary Insurance Company Name		Identification Number		Group Number
Address	City	State	Zip Code	Telephone
Policyholder *(if other than patient)*		☐ Male ☐ Female		Date of Birth
Social Security Number *(of policyholder)*	Telephone *(of policyholder)*			Relationship to Patient
Employer *(of policyholder)*				

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREATMENT

I hereby assign all medical benefits to which I am entitled to Pursuit Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 2% per month (24% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Pursuit Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Authorized Signature	Date

PURSUIT P.T.

Somatic Physiotherapy

Neal O'Neal P.T.

Non-Covered Services Member Consent Form

I,_____, understand that the services and or supplies listed below may not be considered eligible for benefits; they may be determined to be not medically necessary, non-covered or investigational by my health insurance company. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed below, **I agree to be financially responsible for any and all related charges, if not covered by my insurance**.

Physical Therapy evaluation, Therapeutic Activities, Manual Therapy

Services/Supplies Requested

Condition/Diagnosis

$150 to $ 270

Approximate Cost per visit

Patient Signature:_____ Date:_____

PURSUIT PT 7970 170th Ave NE Redmond, WA 98052
Appointments: 206 856 9305 FAX 425 881 1022