JOURNEY
PHYSICAL THERAPY

Patient Information

Patient Name:	DOB:
Address:	City/Zip:
Phone:	Cell Phone:
Email:	
Emergency Contact:	Relation to Patient:
Emergency Contact Phone:	
Referring Physician Name:	Referring Physician Phone:
How Did You Hear About Us?	

Insurance Information

Policy ID #:	Group #:
Policy Holder:	DOB:
Insurance Provider:	Provider Phone:

Worker's Compensation

W/C Carrier:	W/C Phone:
W/C Address:	W/C City & State:

Auto Injury

Attorney Name:	Attorney Phone:
Attorney Address:	Attorney City & State:

We strive to provide you with the most accurate benefit information. However, this is not a guarantee of coverage. Should you feel that the information provided to you may be in error we encourage you to contact your insurance carrier. Co-Payment amounts are specified by the terms of the member's benefit agreement and are the patient's responsibility at the time of service.

I hereby authorize the above information as accurate. Any remaining unpaid balance will be my responsibility.

Signed: _____Date: _____