Dr. Physio
THERAPY & WELLNESS

LOCATIONS
4324 N Federal Highway,
Fort Lauderdale, FL 33308
3205 S Federal Highway,
#8 Delray Beach, FL 33483

CONTACT US
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(954) 206 - 7733
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PATIENT INFORMATION

Name:_____ Date of Birth:_____/_____/_____

Address:_____ City:_____

State:____ Zip:_____ Phone: _____ Cell: _____

E-Mail address:_____

Emergency contact:_____ Emergency contact number:_____

Primary Care Physician:_____ Phone #:_____

Referring MD:_____ Phone #:_____

Primary Insurance: _____ Member ID #: _____

Secondary Insurance: _____ Member ID #: _____

How did you find out about us?__Physician__Referral__Website__Event___Other:_____

_____

MEDICARE PATIENTS ONLY:

Have you had any physical, speech or occupational therapy so far this year? ___Yes ___ No

If YES, where and when did you have it: _____

Do you have a home health care agency coming to your house? ___Yes ___ No

If YES, what is the agency and what is the phone number: _____

_____

I hereby authorize and instruct my insurance carrier to pay Dr. Physio Therapy & Wellness, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all copays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee of 23% of account balance. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

_____ _____/_____/_____

Patient's Signature or Legal Representative Date