CHAMPIONS
RECOVERY ROOM

PATIENT INFORMATION

First Name_____ Middle Initial _____ Last Name_____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth ____/_____/_____ Home Phone: _____ Cell Phone:_____

Referring Physician: _____ Phone Number: _____

Emergency Contact Name and Phone:_____

Employer: _____

Address: _____ City: _____ State: _____ Zip:_____

Email Address: _____ Email Appointment Reminders: Yes: ____ No: _____

Married: ____ Single: ____ Divorced: ____ Other: ____ If Married, Spouses Name: _____

Spouses Date of Birth: _____/_____/_____ Spouses Employer:_____

INSURANCE INFORMATION

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____

Secondary or Other Insurance: Yes: _____ No: _____

Insured Party: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Group Number: _____

Patient Financial Obligation Agreement: **I understand that all applicable copayments and deductibles may be collected upon check-in for each visit. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I understand that patient/patient's family is responsible to pay all fees accrued, regardless of insurance verification or anticipated insurance coverage. I understand all insurance plans are different and its impossible for Champions Recovery Room and Physical Therapy to know the specifics of my insurance plan(s) and/or if my plan will reimburse for services received. I agree to pay all fees within *30 days* after bill has been mailed. In the event of a returned or invalid payment, as well as an unpaid balance over 90 days, I agree to pay any and all additional associated costs of banking, legal, and/or collections fees.**

I understand that I am ultimately responsible for payment of all services received. I understand I am advised to fully know and understand my insurance benefits prior to receiving physical therapy services. I agree to pay all fees accrued for services received.

I authorize my insurance benefits be paid directly to Champions Recovery Room and Physical Therapy for services rendered. I authorize representatives of Champions Recovery Room and Physical Therapy to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Patient or Guarantor Name (Print): _____

Patient or Guarantor Signature: _____ **Date:** _____