Keeney Physical Therapy

8485 SW Godwin Court, Portland, OR 97223

Phone (503) 452-7767

PATIENT INFORMATION

Patient Name: ____ Date: _____________

Address:____

____

(city) (State) (Zip Code)

Home Phone: _______________________Work Phone: _________________________

Cell Phone:_________________________ e-mail_____________@_______________

Married: Y N Sex: M F Age: ________________ Date of Birth: _____________

Employer: _________________________________

Person to Contact in Emergency:____

Phone: ________________________

Referring Physician:_______________________________ Phone: _______________

Primary Insurance Company:____

ID # __________________________ **Group:**_________________________________

Insurance Address:____

Secondary Insurance:____

ID #_____________________________ **Group:**_______________________________

Insurance Address: ____

Auto Accident: Y or N

Date of accident: ___/___/____ Claim #: ____________________________________

Name of Auto Insurance____

Address____

Adjuster Name: ____

Phone: ________________________________

I acknowledge that I am financially responsible for all the charges at the time of service. If for some reason I am not able to pay at time of service, I understand my future appointments may be rescheduled until the owed amount is paid. If it becomes necessary to effect collections of any amount owed on this or subsequent visits the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize this office to release information necessary to secure the payment of benefits. A photocopy of this signature is valid as the original.

Signature:_____________________________________Date: ____________________