CROSSROADS
PHYSICAL THERAPY

Patient Information - Complete all sections

Patient Name: _____

Date of Birth:_____ Age: _____ Male: □ Female: □

Address: _____

Home Phone: _____Cell: _____Work: _____

Email: _____

Appointment Reminders: Yes □ No □ If yes, do you prefer Voice: □ Text: □ Email: □

If voice or text, which number: _____

Parent or Guardian (if patient is a minor): _____

Employer or School:_____

Occupation: _____

Referring Physician: _____

Phone: _____ Fax: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Emergency Contact:

Name: _____ Phone: _____

Relationship: _____

Insurance:

Primary Insurance Company: _____

Contact Phone Number: _____

Regarding Insurance:

* Crossroads Physical Therapy is a fee for service business and does not bill health insurance. This information is only collected to help you in navigating the process of reimbursement for out of network services.
* If you use Medicare services, you will not be able to submit for reimbursement by Medicare.
* I**t is your responsibility to understand your insurance benefits.** Please use the provided list of questions on the website to make sure you understand if you require a referral or pre-authorization before coming in. Please be aware of expectations for your out of network benefits.