Restor Physical Therapy
P.O. Box 8125
Fountain Valley, CA 92728-8125
Office: 714-754-7268
Fax: 714-434-7042

Last Name: _____ First Name: _____ M I: _____ M/F _____

Address: _____ City/State/Zip _____

Home Phone #: _____ Cell Phone #: _____ Email: _____

Date of Birth: _____ SS#: _____ Referring Physician: _____

Primary Care Physician, if other than referring Physician: _____

Employer: _____ Occupation: _____ Work Phone: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

**********BILLING INFORMATION**********

Related to Work Injury or Automobile - Yes or No: _____ Date of Injury: _____

Claim #: _____ Auto – Do you have MedPay on Policy: _____

IF OTHER THAN ABOVE:

Relationship to the Insured for Primary Insurance: Self Spouse Child Other

Insured's Employer _____

Relationship to the Insured for Secondary Insurance: Self Spouse Child Other

Insured's Employer _____

Are you presently receiving Home Health Care? (Yes or No) i.e. home companion, visiting nurse

Name of Agency _____

Have you recently finished Home Health Care? (Yes or No)

Name of Agency _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Policy Holder Name: _____

**********HIPAA**********

I have been offered a copy of the notice of privacy practices and have accepted or denied the offer. I give my consent that my health information cam be used for the purpose of treatment, payment, and health care operations.

Signature: _____ Date: _____

**********PAYMENT POLICY**********

I authorize payment to be made and/or sent directly to Restor Physical Therapy. I agree to be responsible for any unpaid balances for services rendered. I agree to pay my Deductible and or Copayment upon each visit. I understand that verification of my Insurance does not guarantee payment from My Insurance Company and that I will be responsible for payment to Restor Physical Therapy if Insurance denies payment.

Signature: _____ Date: _____