Dynamic Bracing & Physical Therapy

405 E. Pacific Ave
Spokane, WA 99202

Phone: 509-325-9144
Fax: 509-325-0422

PATIENT INFORMATION (Must be completed)		
Last name:	First name:	Middle initial:
Social Security #:	Birth date:	Male Female
Address:	Single Married Divorced Other	
City:	State:	Zip:
Home Phone:_____ Cell Phone:_____ Email: _____ OK to leave detailed message? Yes No	Employer:_____ Occupation:_____ Phone:_____ OK to leave detailed message? Yes No	
Minor: Yes No Parent/Guardian:_____ Phone if different than above:_____	Emergency Contact: _____ Phone:_____	
Prescribing Physician:	Diagnosis:	
Date of Injury: How Occurred?:		
Supply or Treatment Needed:	Have you had PT this year? Date:	

PRIMARY INSURANCE/ WORKERS COMP	**SECONDARY INSURANCE**
Insurance Co.	Insurance Co.
Address:	Address:
Phone:	
ID or Claim Number:	Phone
Group Number:	ID Number:
Claim Manager:	Group Number:
Subscriber:	Subscriber:
Subscriber Date of Birth:	Subscriber Date of Birth:

How did you hear about us?_____

Release of Medical Information, Authorization, Acknowledgement of Financial Responsibility:

1) I authorize my physicians, doctors, nurses and other health care providers to furnish any and all information and opinions, which may be requested, regarding billing information and/or my physical condition to Dynamic Bracing and Physical Therapy, Inc.(DBPT) and/or _____ I also authorize DBPT or any other holder of medical information about me to release to my insurance company and or Center for Medicare and Medicaid Services and it agents any information needed to determine benefits payable for related services. _____***initial***

2) I have received a copy of DBPT's financial policy and understand that I am responsible for charges associated with medical services and agree to pay all bills within 30 days from the receipt of statement, unless other arrangements are made. I request that payment of authorized Insurance, Medicare and or Medigap benefits be made on my behalf to DBPT for any services furnished to me by DBPT. _____***initial***

3) I certify that I have received a copy of DBPT's Notice of Privacy Act, Patient Bill of Right and Patient Complaint Resolution. _____*initial*

Signed:_____ Date:_____
Patient/Guardian/Responsible party signature