

# BATTLE GROUND/RIDGEFIELD PHYSICAL THERAPY PATIENT ACQUAINTANCE RECORD

## PATIENT INFORMATION

ACCOUNT #: \_\_\_\_\_  
TODAY'S DATE: \_\_\_\_\_  
REFERRING PHYSICIAN: \_\_\_\_\_

NAME: \_\_\_\_\_  
FIRST MIDDLE LAST  
ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP  
TELEPHONE #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ SSN #: \_\_\_\_\_  
EMPLOYERS ADDRESS: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
SPOUSES NAME: \_\_\_\_\_  
SPOUSE'S EMPLOYER: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
NAME OF PERSON NOT LIVING WITH YOU TO CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_  
TELEPHONE #: \_\_\_\_\_

## INSURANCE INFORMATION

INSURED'S NAME: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_ ID/SSN #: \_\_\_\_\_  
TELEPHONE #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
SECONDARY INSURANCE: \_\_\_\_\_ ID/SSN #: \_\_\_\_\_  
TELEPHONE #: \_\_\_\_\_ GROUP #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

## COMPLETE ONLY IF ON THE JOB INJURY:

STATE IN WHICH INJURY OCCURRED: \_\_\_\_\_

EMPLOYER AT THE TIME OF INJURY: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CLAIMS ADJUSTER: \_\_\_\_\_ CLAIM #: \_\_\_\_\_

## COMPLETE ONLY IF AUTO ACCIDENT: BILL MY INSURANCE \_\_\_\_\_ OR OTHER PARTY'S INSURANCE \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_  
INSURANCE COMPANY: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CLAIMS ADJUSTER: \_\_\_\_\_ CLAIM #: \_\_\_\_\_  
NAME OF INUSRED: \_\_\_\_\_ RELATIONSHIP TO THE INSURED: \_\_\_\_\_  
PLEASE NOTE: EVEN THOUGH YOU MAY NOT BE AT FAULT WITH REGARD TO THIS ACCIDENT, IT IS BEST TO BILL YOUR INSURANCE COMPANY.  
THEY IN TURN WILL RECOVER FUNDS FROM THE RESPONSIBLE PARTY.  
ATTORNEY'S NAME: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_

**BILLING POLICY:** BATTLE GROUND PHYSICAL THERAPY WILL BILL ALL INSURANCE COMPANIES DIRECTLY IF WE HAVE THE PERTINENT BILLING INFORMATION. WE WILL BILL SECONDARY INSURANCES FOR MEDICARE PATIENTS ONLY.

I HEREBY AGREE TO HAVE THE INSURANCE BENEFITS SENT DIRECTLY TO B.G.P.T. I FURTHER UNDERSTAND THAT I AM RESPONSIBLE FOR ANY BALANCE DUE THAT THE ABOVE MENTIONED INSURANCE CARRIER DOES NOT COVER AND PAYMENT OF THIS BALANCE WILL BE MADE WITHIN 30 DAYS UNLESS OTHER ARRANGEMENTS ARE MADE. ACCOUNTS OVER 90 DAYS PAST DUE MAY BE SUBJECT TO A \$5.00 REBILLING FEE. I ALSO AUTHORIZE B.G.P.T. TO RELEASE TO THE ABOVE MENTIONED INSURANCE COMPANY ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEFITS.

\_\_\_\_\_  
RESPONSIBLE PARTY'S SIGNATURE

\_\_\_\_\_  
PATIENT'S SIGNATURE

\_\_\_\_\_  
DATE