Clinic: Muskego / New Berlin REASON FOR CALL _____ INJURY DATE: _____
Physical Therapist: _____Amy J. Helminski PT, MS, OCS _____Heidi Feuling PT, DPT

PATIENT INFORMATION

TODAY'S DATE: _____ EVALUATION DATE: _____

NAME: _____ MALE FEMALE (Circle one)

Address: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ E-MAIL: _____

DOCTOR/REFERRAL SOURCE: _____

IN CASE OF EMERGENCY, NOTIFY: _____PHONE: _____

BIRTHDATE: _____/_____/_____ SOCIAL SECURITY NUMBER: _____/_____/_____

EMPLOYER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ MEMBER ID: _____

PRIMARY INSURANCE PHONE #: _____ GROUP NUMBER: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____/_____/_____ BIRTHDATE: _____/_____/_____

POLICY HOLDER'S EMPLOYER: _____

SECONDARY INSURANCE: _____ MEMBER ID: _____

SECONDARY INSURANCE PHONE #: _____ GROUP NUMBER: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____/_____/_____ BIRTHDATE: _____/_____/_____

POLICY HOLDER'S EMPLOYER: _____

AUTHORIZATION FOR TREATMENT: I give my consent to undergo examination and treatment by the staff at **Advance Physical Therapy**.
PATIENT SIGNATURE: _____DATE:_____

AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS: I authorize the release of any information required to act on this claim and permit photographic or further facsimile reproduction of this authorization to be used in place of the original. I hereby assign to **Amy Helminski PT MS OCS**, doing business as **Advance Physical Therapy Services, LLC** the medical benefits I am entitled to for Physical Therapy service from my insurance company.
I am responsible for any charges not paid for by my insurance company. *By listing my email address and cell phone number, I authorize Advance Physical Therapy Services, LLC to send emails and text messages to me.
PATIENT SIGNATURE: _____DATE:_____