Colorado Physical Therapy Specialists

Personal Information

Please Print

Name:____

Address:____

City:______________________________ State:_____ ZIP______________

Daytime Phone:______________________________Mobile Phone:____________________________

Home Phone: __________________________Email:____

Birthdate:___________________ Gender: Female _____ Male ______ Marital Status: _____________

Emergency Contact Name:____

Phone Number: __________________________________ Relationship: ________________________

How did you hear about us? (please specify)

Physician: (name) ____

Friend/ColPTs patient: (name) ____

KUNC ad______ Brochure______ Other_______________________________________

Auto Accident Related? YES NO

Work Related Injury? YES NO

If you answered "yes" to either question above: Date of injury: __________________

Referring Physician:_____________________________

City:___________________State:____________

Phone:__________________________________

Primary Physician:______________________________

City:___________________State:____________

Phone:__________________________________

- **If you will be submitting to Medicare**: Medicare requires that an actual doctor's visit must occur every 90 days to continue physical therapy coverage.

- If **you** plan to bill your insurance company, the insurance company may require a physician authorization. Please check with your individual insurance company.

By signing below:

- I authorize Colorado Physical Therapy Specialists to release to my insurance company or my doctor any information they may request concerning my present illness or injury.

- I accept responsibility for the cost of services and understand that payment is due at the time of service.

- I authorize Colorado Physical Therapy Specialists to evaluate and treat my condition with standard physical therapy procedures.

- I understand if I do not show up for an appointment or cancel an appointment with less than 24 hours notice **twice**, I may not be able to schedule future appointments.

Patient Signature:____ ____________________

(Signed by parent or guardian if under age 18 or dependent) **Date**