PHYSICAL THERAPY @ THE PACIFIC CLINIC

1350 NORTH GRANT STREET KENNEWICK, WA 99336 PHONE: (509) 735-2014 FAX: (509) 735-3980

PATIENT INFORMATION

NAME: ____________________

DATE OF BIRTH: ____________ MALE: ☐ FEMALE: ☐ SSN: ____________

STREET ADDRESS: ____________________ APT/SUITE: ________

CITY: ____________________ STATE: ________ ZIP: ________

THIS PRACTICE PERFORMS CLINICAL NOTIFICATION VIA CALLS, EMAILS AND TEXT MESSAGES. BY CHECKING THE BOXES BELOW AND PROVIDING CONTACT INFORMATION, YOU ARE GIVING CONSENT FOR OUR CLINIC TO DO SO.

☐ HOME PHONE: (_______) ____________

☐ CELL PHONE: (_______) ____________

☐ EMAIL: ____________________

EMERGENCY CONTACT

NAME: ____________________ PHONE: (_______) ____________

INSURANCE

EMPLOYER: ____________________ OCCUPATION: ____________________

AUTOMOBILE ☐ COMMERCIAL ☐ SELF-PAY ☐ WORKMEN'S COMPENSATION ☐

PRIMARY: ____________________

ID/POLICY #: ____________________ GROUP #: ____________________

SECONDARY: ____________________

ID/POLICY #: ____________________ GROUP #: ____________________

DATE OF INJURY/ACCIDENT: ____________

CLAIM MANAGER: ____________________ PHONE #: ____________________

GUARANTOR INFORMATION

WE ARE NO LONGER PROVIDERS FOR STATE INSURANCE PLANS AND DO NOT BILL OR ACCEPT PAYMENT FROM ANY STATE INSURANCE PLAN, REGARDLESS IF IT IS PRIMARY OR SECONDARY.
(I.E. MEDICAID, COORDINATED CARE, APPLE HEALTH, MOLINA). _____ (PATIENT/GUARANTOR INITIALS)

I ASSIGN MEDICAL AND/OR MAJOR MEDICAL BENEFITS TO PHYSICAL THERAPY @ THE PACIFIC CLINIC AND AUTHORIZE PHYSICAL THERAPY @ THE PACIFIC CLINIC TO PROVIDE AND RECEIVE ANY MEDICAL INFORMATION NECESSARY TO BILL AN INSURANCE/THIRD PARTY AND RECEIVE A DIRECT PAYMENT FROM LISTED INSURANCE/THIRD PARTY.

I UNDERSTAND THAT REGARDLESS OF MY INSURANCE COVERAGE, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR PROFESSIONAL SERVICES RENDERED BY PHYSICAL THERAPY @ THE PACIFIC CLINIC AND ARE DUE UPON RECEIPT. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW INFORMATION PERTAINING TO MY INSURANCE PLAN/THIRD PARTY BILLING COMPANY AND THEIR BENEFITS, LIMITATIONS ETC.

PATIENT/GUARANTOR NAME: ____________________

PATIENT/GUARANTOR SIGNATURE: ____________________ DATE: ________