642 North 1000 West, Ste. 107
Logan, UT 84321
Phone: (435) 753-1556
Fax: (435) 753-7305

Last Name:_____ First:_____ M.I.____

Birth Date:_____ SSN:_____ Sex: M F

Street Address:_____ City:_____ Zip Code:_____

Home Phone:_____ Cell Phone: _____ Email address: _____

Referring Doctor:_____ Date of Next Doctor's Visit:_____

Date your problem started:_____ Diagnosis:_____

Is this problem work related? ☐ Yes ☐ No (If yes please complete the following information)

Employer:_____ Employer Contact:_____

Employer Address: _____Work Phone:_____

Your Job Title:_____ How long at this position: _____

Personal Insurance (Please present your card for copying)

Name on Insurance Card:_____ Insured's Birth Date:_____

Insured's SSN:_____ Insured's Employer:_____

Primary Insurance:_____ ID#:_____

Address:_____ Zip Code:_____

Phone #: ( ) _____ - _____ Group #:_____

Secondary Insurance:_____ ID#:_____

Address:_____ Zip Code:_____

Phone #: ( ) _____ - _____ Group #:_____

Company Insurance

Workers Comp Insurance:_____

Address:_____ Zip Code:_____

Phone #: ( ) _____ - _____ Claim #:_____

CONSENT AND RESPONSIBILITY

Consent for services: Consent is hereby given to TEAMWORKS! THERAPY, its contractors, medical staff, and employees to provide facility and other health care services to me and to administer physical therapy orders for my behalf. If I desire further information, I will make certain that the health care provider explain my condition and proposed treatment and answer my questions about the treatment and its risks in a satisfactory manner.

Release of Information: Permission is given for TEAMWORKS! THERAPY, its contractors, medical staff and employees to release medical and other information about my case to insurance companies, to other third party payers who are or may be responsible to pay for all or any part of my health care services, and to the agents or representatives of such companies or payers. Such information may be released without further authorization for the purpose of making, completing and verifying claims and the receipt of services, in connection with prospective, concurrent, or retrospective review related to such health care services and the payment of such services. I also authorize the above named medical facility to release information to my employer or other medical specialist involved in the treatment of my case.

Responsibility: I understand that I am responsible for full payment of all charges incurred in connection with this visit, unless this is an industrial accident, in which case it will be covered by my employer's workers' compensation industrial carrier, or unless the service has been requested by my employer or prospective employer. I understand that if workers' compensation is denied for any reason, I am financially responsible

SIGNED:_____ DATE:_____