Lowcountry
Physical Therapy Associates

8-B Farmfield Avenue · Charleston, SC · 29407
(P) 843.266.9200 (F) 843.266.9201

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____-_____-_____

Date of Birth: _____-_____-_____ Age: _____ Sex: _____

Home Address: _____

City: _____

State: _____ Zip: _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Work Phone: (____) _____-_____ Employer: _____

Occupation: _____

Name of Spouse: _____ His/Her Employer: _____

Emergency Contact: _____ Phone: (____) _____-_____

Referring Physician: _____

Date of injury / date of onset: _____ Is this the result of an accident? _____

If yes, what type of accident? AUTO / WORK / OTHER: _____

Insurance Information:

Primary Carrier: _____

Insured: _____

Insured's Date of Birth: _____

ID#:_____

Phone: (____) _____-_____

Secondary Carrier: _____

Insured: _____

Insured's Date of Birth: _____

ID#:_____

Phone: (____) _____-_____

Assignment and Release:

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to Lowcountry Physical Therapy Associates, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Lowcountry Physical Therapy Associates, LLC may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services

_____ _____

Signature of Patient, Parent, Guardian Date