Canyon Sports Therapy
PHYSICAL THERAPY & SPORTS BIOMECHANICS

PATIENT INFORMATION FORM

First Name_____ M.I. _____ Last Name_____

DOB_____ Sex_____ Phone # _____

Home Address_____

City _____ State _____ Zip _____

Employer_____ Address _____ Phone _____

Email Address _____

Emergency Contact_____ Relationship_____

Responsible Party (if patient is a minor/under guardian care)_____

Responsible Party Home Phone_____ Cell/Work_____

How were you referred to our clinic?_____

INSURANCE INFORMATION

As a courtesy to you, Canyon Sports Therapy will bill your health plan(s). Understand that it is your responsibility to verify your coverage for our services. *We do not participate with all insurance plans.*

Primary Insurance_____ Phone (see card)_____

Member ID#_____ Group Number_____

Policyholder Name _____ Relation to Patient_____

Secondary Insurance_____ Phone (see card)_____

Member ID#_____ Group Number_____

Policyholder Name_____ Relation to Patient_____

I hereby agree to be treated by Canyon Sports Therapy Inc and I accept responsibility for payment of all charges incurred from services provided. I understand my health plan(s) will be billed and I agree to pay any remaining portion my health plan designates as my responsibility, per my contract with them. I also understand that I am solely responsible for pre-verifying my insurance coverage for any services Canyon Sports Therapy provides me.

I acknowledge that Canyon Sports Therapy is not an in-network provider for all health plans and that I will be fully responsible for charges not covered by my health plan(s).

I understand that I'll be charged a $40.00 fee, not billable to my health plan, if I don't provide Canyon Sports Therapy at least 24 hours' notice in the event I need to cancel or reschedule an appointment.

_____ _____

Signature of Responsible Party Date