Peak Performance Therapy, LLC

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PPTCUS.com

Patient Information

Patient Information

Last Name: ______________________________ First Name: __________________________ MI: _______

Address1: ____

City: ______________________________State: __________________________ Zip: _________________

Address2: ____

City: ______________________________State: __________________________ Zip: _________________

Home Phone: ______________________ Work: ____________________ Cell: _____________________

Date of Birth: __________________ Gender: M / F Email: __________________________________

Emergency Contact

Last Name: ________________________ First Name: _________________ Relationship: ______________

Home Phone: ______________________ Work Phone: ________________ Cell Phone: _______________

Primary Insurance

Insurance Company: ____

Insurance ID #:_______________________________ Group #: ___________________________________

Secondary Insurance

Insurance Company: ____

Insurance ID #: __________________________________ Group #: ________________________________

Tertiary Insurance

Insurance Company: ____

Insurance ID#: ______________________________ Group#: _____________________________________

I authorize release of information requested by my insurance plan for payment. I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration Form.
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. (You have a right to refuse to sign this acknowledgement if you so choose.)

Signature: ____ **Date:** ______________