301 N 3rd St
Coeur d'Alene, ID 83814
Phone 208-215-2210
FAX 208-215-2209
www.activenwpt.com

PATIENT NAME_______________________________________NICKNAME______________ MALE_____ FEMALE_____

PRIMARY PHONE___________________SECONDARY PHONE____________________EMAIL_________________________

ADDRESS____CITY__________________STATE_______ZIP____________

BIRTHDATE_________________ SSN#_______________________ SINGLE______MARRIED______

PATIENT'S EMPLOYER____ PHONE________________________

SPOUSE'S NAME_____________________________________ SPOUSE'S EMPLOYER______________________________

RESPONSIBLE PARTY (if different from patient):
NAME____BIRTHDATE_______________________

ADDRESS____PHONE__________________________

EMERGENCY CONTACT______________________________PHONE_____________________RELATIONSHIP____________

Whom may we thank for referring you to ActiveNW Physical Therapy & Wellness? ______________________________

REFERRING PROVIDER_____________________________PRIMARY CARE PROVIDER_____________________________

WHAT CONDITION ARE WE TREATING YOU FOR? ____

IS THIS CONDITION THE RESULT OF AN INJURY OR ACCIDENT? YES/NO

If no injury involved, please skip to Health Insurance Information (Section C) below.

DATE OF INJURY: _______________ HOW WERE YOU INJURED? ____

A) DID THE INJURY OCCUR AT WORK? YES/NO HAVE YOU FILED A CLAIM WITH YOUR EMPLOYER? YES/NO

WORKER'S COMPENSATION INSURANCE INFORMATION

Name of employer who claim is filed with________________________________Phone______________________

Insurance Carrier for this claim____________________________Claim #_________________Adjuster__________

B) DID THE INJURY OCCUR AS THE RESULT OF AN AUTO ACCIDENT? YES/NO STATE WHERE MVA OCCURRED____

AUTO INSURANCE INFORMATION – Have you filed this with your own auto insurance? YES/NO

Patient's Auto Insurance____Phone__________________________

Policyholder Name____ Claim #________________________________

Responsible Party's Insurance____________________________________ Policyholder Name___________________

C) HEALTH INSURANCE INFORMATION

INSURANCE COMPANY____

SUBSCRIBER NAME__________________________________RELATIONSHIP TO PATIENT______________________

SUBSCRIBER ID#___________________________________GROUP #______________________________________

I authorize my insurance company (or attorney if applicable) to make payment directly to ActiveNW Physical Therapy & Wellness. I authorize the release of information necessary to process my claim and I acknowledge I have received notice of privacy practices. I understand it is my responsibility to have any pre-certification in place if so required by my insurance. I accept full responsibility for the charges incurred.

CREDIT TERMS: balances remaining unpaid on account after the 1st day of the month following the monthly billing statement date are subject to finance charge at the periodic rate of 1.5% per month, which is an annual percentage rate of 18%. We compute the finance charge by applying the periodic rate to that portion on your account which is over 90 days.

____ ____________________________

PATIENT OR GUARDIAN SIGNATURE DATE