Sports Reaction Center
Physical Therapy

1750 112th Avenue NE Suite D-154 Bellevue WA 98004
Phone: 425-643-9778 Fax: 425-643-6448

PATIENT INFORMATION

Name: _____ (Last / First / MI)
Birth date: _____ / _____ / _____ Age: _____ Sex: _____
Address: _____
Social security # : _____ – _____ – _____
City: _____ State / Zip: _____
Marital status: ☐ S ☐ M ☐ D ☐ W
Phone: _____
How did you hear about us? _____
Employer: _____
Referring doctor: _____
Work / cell phone: _____
Area of injury: _____
Email: _____
Date of injury: _____

INSURANCE INFORMATION

Is this an L.T.P.D. Yes ☐ No ☐

Is injury auto related? Yes ☐ No ☐
Auto claim # : _____
Attorney: _____

Is injury work related? Yes ☐ No ☐
L&I claim # : _____
Employer at time of injury: _____
Attorney: _____

Primary insurance: _____
Name of insured: _____
Address: _____
ID # : _____
City: _____
Group # : _____
State / Zip: WA
Insured phone: _____
Phone: _____
Insured social security # : _____

Secondary insurance: NONE
Secondary subscriber # : _____

EMERGENCY

Emergency contact: _____
Relationship: _____ Emergency contact phone: _____

CANCELLATION/ NO SHOW POLICY

Cancellation/ No Show policy: Please notify the office 24 hrs in advance if you need to cancel your appointment so we may schedule another patient. You may be subject to a $25 charge if you do not notify us 24 hrs in advance. No Shows may be subject to $25 charge and limited to day of appointment scheduling. Initial_____

CONSENT FOR TREATMENT

- I consent for medical care and treatment by Sports Reaction Center.
- I authorize Sports Reaction Center to release any information required to process this claim.
- I authorize payment from my insurance company to be made directly to Sports Reaction Center.
- I understand that whatever my insurance company does NOT pay and/or employer's company does NOT authorize, I am responsible for the full payment balance.
- I understand that if I voluntarily suspend or terminate care at any time, my portion of all charges for professional services are due and payable to the Sports Reaction Center. All services rendered by the Sports Reaction Center are charged directly to me, and I, ultimately, will be responsible for payment regardless of my insurance coverage.

Responsible party signature: _____ Date: _____