APEX
PHYSICAL THERAPY SPECIALISTS

1314 South King Street #1455
Honolulu, Hawaii 96814
Office: 521-8500 Fax: 521-8501

Patient (Last Name):	(First Name):	Date of Birth:
Address:	City, State, Zip:	Marital Status:
Best Phone # to reach you at:	Secondary Phone:	Email:
Occupation:	Employer/Address:	
Name of Insured:	Insured's Date of Birth:	Relationship to Patient:
Emergency Contact:	Phone:	Relationship to Patient:

Insurance:	Notes:
Date of Injury/Accident (work comp/auto):	
Adjuster Name:	
Phone:	
Fax:	
Claim #:	

Co-Pay: $	Co-Ins: %		
DX Code:	Description:	Ins. Allowed:	Rx #1
DX Code:	Description:	Ins. Allowed:	Rx #2
EX Code:	Description:		Rx #3

Referring Physician:	Next MD Visit:	Have you had any PT this year? If so, how many times?

1 CP	2 CP	3 CP	4 CP	5 CP
6 CP	7 CP	8 CP	9 CP	10 CP
11 CP	12 CP	13 CP	14 CP	15 CP
16 CP	17 CP	18 CP	19 CP	20 CP
21 CP	22 CP	23 CP	24 CP	25 CP
26 CP	27 CP	28 CP	29 CP	30 CP
31 CP	32 CP	33 CP	34 CP	35 CP

Assignment of benefits: I assign and authorize payment of medical benefits directly to Apex Physical Therapy Specialists (APTS). I understand that I am financially responsible for any charges not paid by my insurance company. I will pay APTS in full any outstanding balance in the event my insurance company fails to authorize or reimburse APTS for services rendered. I understand that verification of benefits does not guarantee payment. I hereby authorize the release of any medical information necessary to process my insurance claim to APTS. All copies shall be considered as valid as the original. By signing here I acknowledge the above and will hold harmless APTS and any representative of APTS and that I also am aware of all HIPAA rules and guidelines that were made avaiable for full review at any point during my therapy.

Signature (Required) **Date**