APEX PHYSICAL THERAPY SPECIALISTS

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

Patient (Last Name, First Name):	Primary Phone:	Date of Birth:	Marital Status:
Address:	City, State, Zip:	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 (Clinic Use ONLY):
Date of Injury/Accident (work comp/auto):	
Adjuster Name:	
Phone:	
Fax:	
Claim #:	

Deductable $	Co-Pay: $	Dx:	Rx #1
Referring Physician:	Next MD Visit:	Have you had any PT this year? If so, how many times?	Rx #2 Rx #3

VISIT	DATE	SIGNATURE	CO-PAY:
1			
2			
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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 available for full review at any point during my therapy.

Signature (Required) **Date**