PATIENT INFORMATION

Kinesis Physical Therapy, LLC
9707 Medical Center Drive
Suite 330
Rockville, MD 20850
p (301) 444 - 4090 f (301) 444 - 4091
www.kinesispts.com

Personal Information

Name: _____ SS#: _____
Last First MI

Sex: Male Female Date of Birth: _____/_____/_____ Marital Status: _____

Address: Zip:

Email Address:

Home Phone: ( ) Work: ( ) Cell: ( )

Employer: Occupation:

Insurance Name: Relationship to insured: Self Spouse Other _____

Policy Holder Date of Birth: _____/_____/_____

Emergency Contact: Phone: ( ) Relationship:

Physician Information

Referring Physician:

Primary Care Physician:

Please provide us a copy of your insurance card and a valid photo ID

For Auto Accidents or Workmans Comp.

Date of Injury: Claim #:

Name of Insurance Company: Phone: ( )

Name of Adjuster/Case Manager: Phone: ( )

Name of Attorney: Phone: ( )

***PAYMENT AGREEMENT**: I hereby authorize Kinesis Physical Therapy, LLC to submit medical claims to my insurance carrier or its intermediaries for all covered services rendered to me by Kinesis Physical Therapy, LLC and DIRECT INSURANCE CARRIER OR ITS INTERMEDIARIES TO ISSUE PAYMENT CHECK(S) DIRECTLY TO Kinesis Physical Therapy, LLC. If for any reason my claim is denied and payment for physical therapy is stopped, I agree to pay in full any charges that are outstanding.*

Signature: _____ Date: _____