BREWER PHYSICAL THERAPY

51 Main Rd., Holden, Me 04429
50 Union St., Suite 3100, Ellsworth, Me 04605

NAME _____ DATE OF BIRTH _____

ADDRESS _____ SEX M ◉ F ○

CITY _____ SOC. SEC. # _____

STATE & ZIP CODE _____ HOME PHONE _____

WORK PHONE _____ CELL PHONE _____

EMPLOYER _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

EMAIL ADDRESS _____ (THIS WILL NOT BE SHARED. To be used if interested in occasional newsletters and/or appointment reminders)

☐ HEALTH INSURANCE ☐ WORKERS COMP ☐ AUTO ACCIDENT

Primary Health Insurance
Insurance Co.: _____ ID: _____
Subscriber: _____ Subscriber's DOB: _____

Secondary Health Insurance
Insurance Co. _____ ID: _____
Subscriber: _____ Subscriber's DOB: _____

Worker's Compensation/ Auto Accident Info
Insurance Co.: _____ Contact Person: _____
Employer/Policy Holder: _____ Phone: _____
Claim Number: _____ Date of Injury: _____
Attorney (if involved) _____

PAYMENT POLICY

IMPORTANT… We can bill your insurance as a courtesy. BUT you are responsible for payment of your bills. YOU are responsible to pay for services not paid by your insurance.

If Charges need to go to a collection agency, there will be a 32% fee.

☐ I authorize BPT to release any information necessary to process insurance claims, inform my physician, insurance company, lawyer, case manager, employer or school of my status.
☐ I have been informed of BPT's privacy protection policy and understand that BPT will protect my information from unauthorized release.
☐ I understand the above payment policy.
☐ I authorize insurance payments to be made directly to BPT. I understand my insurance may not pay for all services and materials and accept responsibility to pay for that which is not paid by insurance.

SIGNATURE OF PATIENT _____ DATE _____.
Or Responsible Party