4112 41st Ave S
Seattle WA. 98118
t: 206 328 4606 f: 206 760 4168

Heidi B. Gans
Physical Therapy

Patient Intake a Registration Form

Patient Information

Patient Name:_____ Gender:(circle) M or F
Date of birth:____/____/____ Age:_____ Social Security #:_____
Address: _____City:_____ State:____ Zip:_____
Telephone: home:(____)_____ work:(____)_____ cell: (____)_____
email address:_____Employer:_____
Referring physician name: _____ phone:(____)_____
Primary care provider name: _____ phone:(____)_____
Emergency contact name: _____phone:(____)_____

Primary Insurance Information

Insurance name:_____ phone:(____)_____
Member ID#:_____ group #:_____
Patient relationship to insured: (circle) self spouse/partner child
Name of insured (if not self)_____ Insured's date of birth: ____/____/____

Secondary Insurance Information

Insurance name:_____ phone:(____)_____
Member ID#:_____ group #:_____
Patient relationship to insured: (circle) self spouse/partner child
Name of insured (if not self)_____ Insured's date of birth: ____/____/____

Accident Information

Type of Accident (circle) auto work
Date of accident:___/___/___ Location: (state)_____ Claim#:_____
Adjuster's name:_____ phone:(____)_____
Lawyer's name:_____ phone:(____)_____

Financial agreement: The above information is correct to the best of my knowledge. I understand that I am financially responsible for all charges at the time of treatment whether or not paid by the above insurance. I agree to the release of any medical information my health insurance, attorneys and health care providers may need in order to process payment. I understand that I am responsible for all deductibles, copays and services not covered by my insurance carrier. I understand that a 1% (12%APR) finance charge may be assessed to my account if a balance remains unpaid for 60 days.

_____ _____
patient/Guardian signature date

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Consent to treatment:
I consent to such treatment by Heidi Gans, P.T. as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment accepting acts of negligence.

_____ _____
patient/Guardian signature date

Cancellation Policy:
24 hour notice of cancellation is required. If I must cancel within 24 hours of my scheduled appointment time, I agree to pay the cost of the session in full ($115).

_____ _____
patient/Guardian signature date