BODY ZONE™
PHYSICAL THERAPY

3103 Paper Mill Road • Wyomissing PA 19610
610-376-2100 • FAX 610-750-5806 • bodyzonesports.com/pt

PATIENT INFORMATION

PLEASE CHECK ONE: ☐ NEW PATIENT ☐ RETURNING PATIENT ☐ UPDATING INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST) _____

ADDRESS: _____ EMAIL: _____

CITY: _____ STATE:_____ ZIP CODE: _____

PREFERRED CONTACT NUMBER: HOME_____ CELL_____

DATE OF BIRTH (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER (OPTIONAL): _____ - _____ - _____

MARITAL STATUS
(PLEASE CHECK RELEVANT STATUS): ☐ SINGLE

☐ MARRIED SPOUSE'S NAME (FIRST/LAST):_____

☐ DIVORCED / WIDOWED SPOUSE'S DATE OF BIRTH (MM/DD/YYYY): _____

REFERRING PHYSICIAN:_____

HOW DID YOU HEAR ABOUT US? _____

EMERGENCY CONTACT: _____ CONTACT NUMBER:_____

INSURANCE INFORMATION

PRIMARY INSURANCE:_____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH (MM/DD/YYYY): _____

SECONDARY INSURANCE:_____

NAME OF POLICY HOLDER: _____ DATE OF BIRTH (MM/DD/YYYY): _____

60-DAY COMPLIMENTARY FITNESS MEMBERSHIP

With the mission of helping you reach your full potential, new Body Zone Physical Therapy patients and a family member or special caregiver (who are non-members) are invited to enjoy Body Zone's fitness center with two complimentary 60-day memberships.

☐ Yes! I would like to receive my complimentary 60-day Body Zone membership.

Name of second membership holder is: _____

☐ No, I am not interested at this time.

Details:

1. A Body Zone Member Advisor will be contacting you to activate your memberships.
2. A Body Zone Liability Waiver must be completed for both you and your additional membership holder.

OVER

CONSENT

CONSENT: I hereby consent to physical therapy and incidental medical services to be provided by Body Zone Physical Therapy.

LIABILITY: I understand and agree that Body Zone Physical Therapy will not be responsible for any loss or damage to my personal properties or valuables while I am on the premises of Body Zone Physical Therapy.

RELEASE OF INFORMATION: I allow Body Zone Physical Therapy to provide information to any third party payors or those hired by the third party payor who may be partially or wholly responsible for payment of my physical therapy bill. I allow Body Zone Physical Therapy to release my information to the provider from which I was referred. I allow Body Zone Physical Therapy to release my information to WebPT on my behalf for billing of the said third party payor.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ RELATIONSHIP: _____

PERMISSION TO TREAT A MINOR

This form is valid for one year from the below signed date.

MINOR'S NAME: _____

MINOR'S DATE OF BIRTH: _____

I, (parent/legal guardian), grant permission and authorize the administration of all diagnostic and therapeutic treatment that may be considered advisable or necessary in the judgment of the Therapist/Therapist Assistant at Body Zone Physical Therapy.

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE:_____

PRINT PARENT/LEGAL GUARDIAN NAME: _____