Welcome to **All Star Physical Therapy, Inc**. In order to serve you properly, we will need the following information.
All Information will be strictly confidential. (Please Print)
Corporate Office: 29645 Rancho California Rd. Ste. 234, Temecula, CA 92591

PATIENTS INFORMATION

Patient's Name:	Date of Birth: ____/____/____ Age: _____ Sex: M/F	Patient's Social Security #:
Address: City: State: Zip:		Phone Number:
Reason for Visit:	Referred by:	
Person to contact in case of Emergency:	Relationship to Patient:	Phone:

PRIMARY INSURANCE

Insurance Company:	Policy Number:	Name of Subscriber:	Subscriber Date of Birth:
			_____/_____/_____

SECONDARY INSURANCE

Insurance Company:	Policy Number:	Name of Subscriber:	Subscriber Date of Birth:
			_____/_____/_____

*** Initial here if you do not have a secondary insurance:** _____

RESPONSIBLE PARTY

Responsible Party (Name of authorizing party if patient is under 18 years of age): **Self Y / N** (If Not Self):	Relationship to patient:	Date of Birth of authorizing party: _____/_____/_____

NOTICE OF PRIVACY

I hereby authorize the use or disclosure of my individually identifiable health information as described in the Privacy Practices disclosure for All Star Physical Therapy, Inc.
A copy of the Notice of Privacy Practices will be provided upon my request.

Signature: _____ Date: _____

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to **All Star Physical Therapy, Inc.** for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I also authorize the Interdisciplinary Team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.
Cancellation made with less than 24 hour notice and or missed appointment will result in a $25.00 charge, which will be billed to you.

Signature: _____ Date: _____

Parent or Guardian Signature: _____ Date:_____
(if patient is under 18 years old)