Roaring Fork Physical Therapy
1450 E. Valley Rd, Ste 203, Basalt, CO 81621
(970) 927-9319, fax: (970) 927-0168

Last Name	First	Middle	Soc.Sec. #	
Mailing Address	City	State	Zip Code	Date of Birth
Home phone	Cellular/Work (circle one)		E-mail address	
Marital Status: **Single __Married__ Other____**	**Sex:** **Male ____** **Female ____**	**Notify of appointments by:** **Text ____ or E-mail _____**		
Emergency Contact		*Phone Number*		*Relationship*
Referring Physician	Date of Injury	Employer		Occupation
Primary Insured Member/Cardholder	***Relationship***	***Phone #***	***Birth date***	***Soc Sec #***
Address		***City***	***State***	***Zip***
Insurance Company		Group /Claim #	Subscriber #	

Are you covered by other insurance? If so, list name, address, phone, group # and subscriber #

RELEASE OF TREATMENT AND ASSIGNMENT TO BILL AND COLLECT:

I, the undersigned, understand that the patient is suffering from a condition requiring diagnosis and treatment, including physical therapy. As such, I agree to such diagnostic procedures and treatment, which may be administered or performed on/to the patient for this condition under the instructions of the physical therapist. I authorize the release of medical information to my referring physician (if has such), health agency, government agency or insurance company. *I understand that I am financially responsible for all charges whether or not paid by insurance. I agree to pay legal and collection fees and interest, if applicable*. I authorize medical payment to be sent to Roaring Fork Physical Therapy, P.C. I agree to the terms and conditions of Roaring Fork Physical Therapy's collections and billing policy.

- **Payments are due at time of service for: co-pays, deductibles, co-insurance, and supplies.**
- ***$50 Late fee for Missed/Late Cancel Appts. All non-covered insurance Items are your responsibility.***

I authorize this organization to leave a message on my answering machine. Yes [] No []
I authorize this organization to discuss my condition and account with the person/s listed. Yes [] No []

If yes, please list**:** _____

I authorize the use of my credit/debit card for payment. Yes [] No []

_____ _____ _____ _____
Card Type Number Exp. Date CVC

X _____ **Relation to patient:**_____ **Date:** _____
Signature of Responsible Party