**FREDONIA PHYSICAL THERAPY, PLLC**
**12 BRIGHAM ROAD**
**FREDONIA, NEW YORK 14063**
**(716) 679-7447 phone**
**(716) 679-7446 fax**

Patient Name: _____ Date of Birth: _____

Address: _____

E-Mail: _____

Phone Number: _____ Primary Care Doctor: _____

Emergency Contacts: Please list Name, Phone number, & Relationship:

1. _____

2. _____

FINANCIALLY RESPONSIBLE PARTY

☐ Same as Patient Information (If different, please complete section below)

Name: First_____ Last _____

Relationship: Spouse Parent Guardian Other (Please specify):_____

Address: _____Apt #_____

City_____St_____Zip _____

Phone: _____ Email Address _____

## GENERAL INSURANCE INFORMATION

- **PRIMARY INSURANCE:** _____

SUBSCRIBERS NAME: _____ DATE OF BIRTH: _____

ID #: _____ GROUP #: _____

- **SECONDARY INSURANCE:**_____

SUBSCRIBERS NAME: _____ DATE OF BIRTH: _____

ID #: _____ GROUP #: _____

I hereby certify that the information above is to the best of my knowledge complete and accurate. I understand that I am financially responsible to Fredonia Physical Therapy, PLLC for all therapy services rendered at this clinic whether or not covered by insurance. I also hereby authorize release of information pertaining to my medical condition and therapy treatment to my insurance company, Social Security Administration, or Medicare program.

**STATEMENT TO AUTHORIZE PAYMENT OF BENEFITS:**

I certify that the information given by me in applying for payment is correct. I authorize Fredonia Physical Therapy, PLLC to release any medical information required to process my claim. I request that payment be made to Fredonia Physical Therapy, PLLC for services provided to me.

**You agree to reimburse us the fee of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.**

**SIGNATURE:** _____ **DATE:** _____