Fitness Together-Point Loma
AUTHORIZATION TO TREAT/PATIENT INFORMATION

PATIENTS NAME: _____ MALE / FEMALE DATE OF BIRTH: _____ AGE: _____

PATIENTS ADDRESS: _____ CITY: _____ ZIP: _____

HM PHONE: _____ CELL PHONE: _____ E-MAIL: _____

SOCIAL SECURITY #: _____ DRIVER'S LICENSE#: _____

SPOUSE NAME: _____

PATIENT EMPLOYER: _____ WORK PHONE #: _____

PATIENT OCCUPATION: _____

DATE OF INJURY: _____ DATE OF SURGERY: _____

REFERRING PHYSICIAN: _____ PRIMARY PHYSICIAN: _____
HOW DID YOU HEAR ABOUT US? □Internet □MD Referral □Friend/Family □Advertisement

PERSON TO CONTACT IN CASE OF EMERGENCY:

FIRST AND LAST NAME: _____ PHONE: _____

***IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING:**

PARENT/GUARDIAN NAME_____ SOCIAL SECURITY # _____

PARENT/GUARDIAN EMPLOYER: _____ WK #: _____

PLEASE CHECK METHOD OF PAYMENT:
( ) CASH ( ) PRIVATE INS ( ) MEDICARE
IF YOU HAVE MEDICARE, DO YOU HAVE A SECONDARY INSURANCE POLICY? ( ) Y ( ) N
PLEASE PROVIDE US WITH A COPY OF YOUR INSURANCE CARDS

WAS THIS A MOTOR VEHICLE ACCIDENT? ( ) Y ( ) N IF SO, PLEASE FILL IN THE FOLLOWING:

NAME OF MOTOR VEHICLE INS.: _____ PHONE #: _____

ADJUSTERS NAME: _____ CLAIM #: _____

NAME OF INSURED: _____

DO YOU HAVE AN ATTORNEY? ( ) Y ( ) N

IF YES, NAME: _____ PHONE #: _____

****PLEASE INITIAL THE FOLLOWING:**

___ I HEREBY AUTHORIZE FITNESS TOGETHER-POINT LOMA TO PROVIDE TREATMENT AS PRESCRIBED BY MY PHYSICIAN.

___ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO WHICH I AM ENTITLED TO BE PAID DIRECTLY TO FITNESS TOGETHER-POINT LOMA. I UNDERSTAND THAT IF MY INSURANCE COMPANY/THIRD PARTY PAYER DENIES PAYMENT OR MAKES PARTIAL PAYMENT, THAT I AM RESPONSIBLE FOR THE BALANCE.

___ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO FITNESS TOGETHER-POINT LOMA AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.

___ I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY FITNESS TOGETHER-POINT LOMA. IF MY INSURANCE IS BEING BILLED, I WILL BE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. (THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS.)

SIGNATURE OF PATIENT/GUARDIAN: _____ DATE: _____