

# BreakThrough

## PHYSICAL THERAPY

Newest Research, Fewest Visits, Best Results

Name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(last) (first) (M.I.)

SS number: \_\_\_\_\_ Marital Status: M D S Other Gender: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_ E-Mail address: \_\_\_\_\_

Spouse's full name: \_\_\_\_\_ Spouse's SS# & date of birth \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Emergency contact number: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Referring MD phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone (work): \_\_\_\_\_

Did a family member or friend recommend us to you? Y N If yes, who was the treating PT? \_\_\_\_\_

If no, how did you choose us for your physical therapy? Radio Print Ad MD Location Website

Yellow pages Insurance Other: \_\_\_\_\_

Is your injury/condition a result of a work related incident? Yes No

### Medicare Only

Have you had any physical/speech therapy so far this year? Yes No

If YES, where and when did you have it: \_\_\_\_\_

Do you have a home health care agency coming to your house? Yes No

If YES, who is the agency and what is the phone number: \_\_\_\_\_

Do you have secondary insurance? Yes No

### Workers' Compensation Only

Ins Co: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip \_\_\_\_\_

WCB#: \_\_\_\_\_ Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Date of Injury/accident: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer contact: \_\_\_\_\_

Employer ph #: \_\_\_\_\_ Attorney: \_\_\_\_\_ Attorney ph #: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize and instruct my insurance carrier to pay Carteret Physical Therapy Associates, PLLC D/B/A BreakThrough Physical Therapy, directly for any medical services performed. Additionally, I understand I am financially responsible for payment of all co-pays, deductibles, and balances not covered by Medicare, or my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. I understand that if I default on my account it may be sent to collections, which will result in an additional fee of 23% of account balance. If I am the legal guardian/representative of the patient named above, I accept responsibility for the above as well. I also authorize the release of any and all medical records to my insurance carrier for the purpose of expediting claim payment.

Insured or Authorized Person's Signature

Date

2828 Maplewood Ave., Ste A  
Winston-Salem, NC 27103  
336-765-4703

3700 Symi Circle  
Morehead City, NC 28557  
252-247-2738

1910 N Church St., Ste D  
Greensboro, NC 27405  
336-274-7480

530 Sandhurst Dr.  
Fayetteville, NC  
910-483-9300