BARDSTOWN ROAD

PHYSICAL THERAPY GROUP INC.

Date: _____

Name: _____ SSN: _____

Address_____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

Email: _____ Date of Birth: _____

Sex: M F Marital status: _____ Spouse name:_____

Employer:_____

Person Responsible for Account if different from above:

Name: _____ Relation: _____

SSN: _____ Address: _____

Medical Insurance Information:

Primary Insurance Company: _____

Insurance company address: _____

Secondary Insurance Company: _____

Insurance company address: _____

Policy Holder's Name: _____ Relation: _____

SSN: _____ Date or Birth: _____

I understand that payment is my obligation regardless of insurance or any other 3rd party involvement.

Signature: _____Date: _____

4233 Bardstown Road, Louisville, KY 40218 Phone: 502-493-3800 Fax: 502-493-3830