Advanced Motion
PHYSICAL THERAPY
3665 S 8400 W STE 210 MAGNA, UT 84044 T: 801-250-0755 F: 801-250-5038

PLEASE FILL FORM OUT COMPLETELY TO ENSURE CORRECT BILLING

PATIENT INFORMATION

Name (Last, First, Middle):		SSN#:	Age:	Date of Birth:	Sex: ☐F ☐M
Home Address:		City:		State:	Zip Code:
Home Phone: ( )	Cell Phone: ( )	E-MAIL Address:			

Would you like to receive email notifications about your therapy program and updates from AMPT: ☐Yes ☐ No

Primary Employer:	Occupation:		
Work Address:	City:	State:	Zip code:
Work Phone:	How did you hear about us? Physician / Friend / Family / Advertisement Other:		
Name of Referring Physician:	Date Referring Physician was Last Seen:		

EMERGENCY CONTACT

Name (Last, First, Middle) :	Relationship to Patient:	Day Phone: ( )

INSURANCE INFORMATION

Type of Insurance: ☐ Medicare ☐ Medicaid ☐ Work Comp ☐ Auto ☐ Self Pay ☐ Private ☐ Other

Name of Insurance Company:	Policy / Claim #:		Group #:
Policyholder:	SSN#:	Birth date:	Phone: ( )
Relationship to Patient:	Date of Injury:	Name of Case Manager or Contact Person:	
Address of Insurance Company:			

"NO SHOW /LATE CANCELLATION" POLICY

I _____ understand that there is a **$30 NO SHOW/LATE CANCELLATION FEE** that will be assessed if I do not show up for an appointment or cancel within 24 hours of my scheduled appointment. I also understand that this fee will not be covered by my insurance and will be due on or before my next scheduled appointment.

Please check one of the following boxes for appointment reminders:

☐ **I prefer a reminder call** ☐ **I prefer an E-mail reminder** ☐ **I prefer no reminders**

HIPPA PRIVACY POLICY

I have received a copy of Advanced Motion Inc.'s HIPPA Privacy Policy. ***Please Initial*** ☐

SIGNATURE

Signature of Patient:	**Signature of Parent or Guardian:**	**Date:**