Biltmore PHYSICAL THERAPY

111 Victoria Rd Ste. B
Asheville, NC 28801
828-407-5000

Patient Information

Last name First name Middle initial

____

Address City State NC Zip Code

____

Home phone Cell Email

____

Date of birth SSN Sex: Male ◯ Marital status

______________________________ Female ◯ ____________

please remind me of my appointments by email _______ text message _______ phone call _______

Emergency Contact Information

Contact name Phone number Relationship to patient

____

Physician Information

Referring physician ____

Family physician ____

Additional Questions

Auto related? Work related? Accident related? Body Part/Diagnosis: Date of Injury:

Y ◯ N ◯ Y ◯ N ◯ Y ◯ N ◯ ______________________________

Employment Information

Employer Name: Employment Status: ◯ full time ◯ part time ◯ unemployed ◯ retired ◯ student

____

Address City State Zip Code

____

Work Phone Number Occupation

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I consent to Biltmore Physical Therapy, LLC (BPT) for treatments/procedures that are necessary or advisable for my care.

I hereby grant authorization to BPT to exchange with and/or release requested information on my medical care to insurance carrier(s) and to:

◯ Worker's Compensation ◯ Patient/Guardian ◯ Attorney ◯ Rehabilitation intermediary

I certify that the information furnished by me is correct and hereby direct and authorize payment of health care benefits due me by insurer to BPT. I understand that I am financially responsible for payment of fees regardless of insurance coverage. I also certify that I have received a copy of BPT's payment and cancellation policies.

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Client Signature Date

I have read and understood the BPT privacy notice. I further understand that I may obtain a copy of this privacy notice upon my request.

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Client Signature Date