Ascent Physical Therapy
Lori Schwanz PT, DPT, MS, ATC, LAT, PC
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2712 Bee Caves Rd, Ste110, Austin, TX 78746
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Patient Information Record

Patient Name____
Last First Middle

Address____
Street Apt. City State Zip

Phone____
Mobile Home Office Ext.

Preferred phone number for communication: Mobile ☐ Home ☐ Office ☐

Date of Birth _____/_____/_______ Sex: M ( ) F ( ) Marital Status: Married ( ) Single ( ) Other ( )

Social Security#_______-______-_______ Drivers License#______________________ State________________________

Email ____

Employer Name or School ___________________________________Occupation________________________________

Address____
Street City State Zip

Referring Physician_________________________________Condition____

Spouse/Parent Name______________________________ Work Phone______________ Home Phone_______________

Insurance Policy Holder

Name of Insured__________________________ Date of Birth____/____/_____Relationship to Patient__________________

SSN:_____ - ____ - _____ ID#:__________________Insurance Carrier____________________ Phone________________

Workers Compensation Information
Date of Injury:_______/______/_________ Claim#:____

Adjuster:____ Ph:(____)________________________________

Billing address:____

Local Person to Notify in case of Emergency

Name____ Phone__________________________________

CONSENT TO CARE AND TREATMENT: I, the undersigned, do hereby agree and give my consent to the physical therapists of Ascent Physical Therapy and their designees to furnish medical care and treatment to myself or my child considered necessary and proper by my physician and according to today's standards.
MEDICAL INFORMATION: I authorize the physical therapists of this office to release any information they have acquired in the course of my treatment, or my child's treatment, to my insurance company or companies or any third party payer so that they may obtain payment for medical / physical therapy services rendered.
INSURANCE AUTHORIZATION: I hereby authorize the physical therapists or staff of this office to furnish information to my insurance carriers concerning myself or my child's treatments.
ASSIGNMENT OF BENEFITS: I authorize the insurance company or any third party payer to pay any benefits due directly to this office should they accept assignment on my claim.
I agree that I am financially responsible for the account even though Insurance may be pending on all or a portion of the charges.

Signature of Patient or Parent / Guardian___________________________________**Date**______________________