MAIN OFFICE
396 Danbury Road
Wilton, CT 06897
PHONE (203) 762-5623
FAX (203) 762-9344

SOUTH OFFICE
27 Danbury Road
Wilton, CT 06897
PHONE (203) 761-9710
FAX (203) 762-1349

FULL NAME:	DATE OF BIRTH:
ADDRESS:	SOCIAL SECURITY NO:
ZIP	PHONE NO: (Home)
EMPLOYER'S NAME:	(Work):
ADDRESS:	DATE OF INJURY
ZIP	MEDICARE SELF: SPOUSE:
HEALTH INSURANCE CO:	INSURED'S FULL NAME:
INS. NUMBER:	AUTO ACCIDENT: YES NO
GROUP NUMBER:	INSURANCE CO:
OTHER INSURANCE:	CONTACT PERSON:
REFERRING PHYSICIAN:	WORKER'S COMPENSATION: YES NO
ADDRESS:	INSURANCE CO:
ZIP	EMPLOYER'S PHONE NO:
PHONE NO:	ATTORNEY (IF APPLICABLE)
PRIMARY CARE PHYSICIAN:	ADDRESS:
EMERGENCY CONTACT:	ZIP
RELATIONSHIP: PHONE:	PHONE NO:

How did you hear of Wilton Physical Therapy ____

KNOWING YOUR INSURANCE COVERAGE IS YOUR RESPONSIBILITY
We are not responsible for incorrect information provided to us by your ins. Carrier. Please refer to our Office Policies and Procedures
CANCELLATION NOTICE: 24 hours appreciated; we reserve the right to bill our charge of $50.00 for appointments not cancelled. We will not reschedule if two appointments are missed without cancellation.
BILLING: We bill electronically for most insurance companies. You are responsible for submitting bills not billed electronically and to your secondary insurance carrier. PAYMENT DUE at the time of service includes deductibles, co-pays, percentage of responsibility, and any costs not covered by your primary insurance carrier. Bills not paid in full within 60 days of the time of service are your responsibility and interest may be collected at the rate of 1% per month plus collection cost or legal assistance required for collection. (Exceptions include insurance contracts between Wilton Physical Therapy and your insurance company, for which the insurance company holds responsibility).
You MUST NOTIFY Wilton Physical Therapy office staff of changes in your insurance participation, or referring physician.

Having read the above information, I am aware of my responsibilities and agree to the policies of Wilton Physical Therapy and authorize Wilton Physical Therapy to furnish full details of my medical case to my physicians, attorney (if applicable) and insurance carrier, also to request any reports or records pertaining to my care.

SIGNATURE: ____ DATE: ____________________

If under age 18, parent/guardian: ____