SOS PT, Inc.
148 Linden Street ● Suite B-8
Wellesley, MA 02482
Tel: 781-263-9977 ● Fax: 781-943-4228

SOSPT, Inc.

Spine-Orthopaedic-Sport
PHYSICAL THERAPY

SOSPT #: _____

Name:_____

Address:_____ City:_____

State:_____ Zip:_____ E-mail:_____

Home #:_____Work#:_____ Cell #:_____

Emergency contact:_____Tel:_____

☐ Male ☐ Female Date of birth:_____ SSN:_____

Referral Source Name:_____

If referred by clinician: Specialty:_____
Address:_____
Telephone #:_____

Employment information
Employer:_____
Address: _____
Phone #: _____

Insurance Information
(Although we do not contract with any HMO's or managed care agencies, it is helpful to have your insurance information to assist you with reimbursement when applicable.)
Primary Insurance:_____
Policy Number:_____
Subscriber:_____
Patient's relationship to subscriber (if other than self):_____

Please read and sign:
I recognize that physical therapy services can legally be provided in Massachusetts without a referral from a physician. It is my responsibility to determine if my insurance requires me to have a physician's referral to receive reimbursement for these services.
I recognize physical therapy is a health profession that utilizes the application of scientific principles for the identification, prevention, remediation and rehabilitation of acute and prolonged physical dysfunction thereby promoting optimal health and function.
I acknowledge I am solely financially responsible for my bill and that **payment is due at the time of each visit.**
I authorize **SOSPT, Inc.** to release my records to my insurance company for billing or reimbursement purposes.

Signature:_____ Date:_____