Freedom Physical Therapy & Fitness
5310 Acton Highway, Suite 106
Granbury, TX 76049
Phone 817-326-1375 Fax 817-326-2068

Patient Information

Name: ___________________________________ Date of Birth:____________________________

Cell Phone:________________________________ Home Phone: ___________________________

Work Phone: ______________________________ Sex (optional): M F

Marital Status: Married Single Divorced Widow(er)

Email: ____

Address: ____

City/State/Zip: ____

Employer: ____

Emergency Contact/Phone: ____

Preferred way to receive calls: Cell Home Work Other:__________________

If your insurance is with TRICARE:

Name of Primary Insured:	
SSN:	DOB:

I understand that I am being treated by licensed personnel and I do give my consent to receive this care. I hereby authorize Freedom Physical Therapy to receive the payment directly for the medical benefits payable to me under the terms of my insurance.

Patient or Guardian Signature: ____

I understand that, as a courtesy, this office will file my insurance. I understand that quoted benefits are an estimate of final payment from my insurance and that the final balance is my responsibility. I understand that my ESTIMATED co-pay or co-percentage due at each visit is ______________________.

Patient or Guardian Signature: ____