WIND RIVER PHYSICAL THERAPY LLC
150 Lincoln Street, Lander WY 82520
(P) 307-335-5188 (F) 307-333-0600
email: windriverphysicaltherapy@gmail.com
website: www.windrivertherapy.com

Name:_____ Gender: Male_____ Female_____

DOB:_____/_____/_____ Marital Status: M__S__W__D__

Employer:_____ Employer Address:_____

Mailing address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Home:____ Cell:_____ Work:_____ (check one)

Can we leave a detailed message at the number listed above? Yes____ No____

Email Address:_____
(All emails sent through our online scheduling/billing software are secure.) (All Wind River gmail accounts are **NOT** secure.)

How would you prefer appointment Reminders: Email:___ Text___ Voice call: ___

If phone number or email are different from above please provide:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Can we leave a detailed message with your Emergency Contact? Yes___ No___

Primary Insurance:_____ **Member ID:**_____

Policy Holder's Name/Relation: _____/_____ **Policy Holder's DOB:**___/_____/___

Secondary Insurance:_____ **Member ID:**_____

Policy Holder's Name:_____ **Policy Holder's DOB:**_____/_____/_____

Responsible Party (person to be billed) Check here if same as above:_____ If someone else please fill out below.

Name:_____ Mailing Address:_____

*****How would you prefer your billing statements? USPS:____ email:____**

If address or email are different from above please provide:_____

I have received a copy of the Notice of Privacy Practices. ___ Yes I have.

Signature: _____ **Date:** _____

Insurance notes for your information (FYI)
The patient is responsible for knowing what their insurance will & will not cover for Physical Therapy services; including Medicare. It is highly recommended each patient call his or her insurance company personally to obtain verification of their Therapy coverage. Thanks!